CANADIAN WOMEN'S CONTEMPORARY EXPERIENCES ACCESSING ABORTION

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Abstract

This thesis explores Canadian women's contemporary experiences accessing abortion. Abortion is a women's health issue, yet little nursing research addresses women's experiences or well-documented barriers to care. After Health Canada's approval of the abortion pill, Mifegymiso (RU-486) in 2015, women had an alternative to surgical abortion. This qualitative study uses narrative and critical feminist approaches, and purposive convenience sampling to explore Canadian women's experiences of abortion and access to care. Seven women over the age of 18, diverse in age, education, sexual orientation, geography and experience with medical or surgical abortion completed semi-structured interviews. Critical analysis illustrated the complex, varied meanings that abortion has for women, including the motherhood journey (regardless of whether or not they considered themselves mothers), the pivotal nature of support, and barriers to access. Implications for nursing include challenging the silence in research and augmenting reproductive justice approaches.

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Chapter 1: Introduction and Background

In this study I explore the phenomenon of abortion access in a contemporary Canadian context. Abortion is a women's health issue that is part of a long history of women's health advocacy locally and globally to enable women to control their own reproductive health as a strategy to improve their wellbeing and their everyday lives (Saurette & Gordon, 2015; Stettner, 2016). Estimates suggest that between one in four and one in three Canadian women will have an abortion during her lifetime (Dunn & Cook, 2014; Norman, 2012). There are two types of abortion: surgical and medical abortion (Dunn & Cook, 2014). Medical abortion (use of a pill) is common elsewhere in the world, however, surgical abortion is currently the most common type of abortion performed in Canada, although, there is indication that this trend may be changing (Dunn & Cook, 2014; Grant, 2019; Vogel, LaRoche, El-Haddad, Chaumont, & Foster, 2016).

The experience of abortion access is a timely issue in Canada, with Health Canada approving the long-awaited medical "abortion pill" Mifegymiso (RU-486) in July 2015, and first distributing it in Canada in January 2017 (Government of Canada, 2016; Grant, 2017; Star Editorial Board, 2017). Mifegymiso, more commonly known throughout the world as "the abortion pill", is a drug that has been available in France for 29 years (Grant, 2017). In a country as vast as Canada, it has been suggested that the availability of Mifegymiso could greatly improve access to abortions for many women, particularly for women living in rural settings (Cano & Foster, 2016; Foster et al., 2017; Kaposy, 2010; Sethna & Doull, 2013). Despite the July 2015 approval of Mifegymiso, launch and distribution delays prevented many women from easily accessing Mifegymiso (Grant, 2017; Hudes, 2017).

Initially, part of the delay was attributed to provinces whose governments decided to wait for the Canadian Drug Expert Committee's (CDEC) recommendations before taking action to

cover the costs of Mifegymiso (Grant, 2017). On April 18, 2017, the CDEC announced its recommendations that provincial and territorial governments reimburse the costs of Mifegymiso medical terminations (Canadian Agency for Drugs and Technologies in Health, 2017). However, while waiting for provincial/territorial universal coverage to take effect, there were reports of Canadian women paying for Mifegymiso costs out of pocket (Grant, 2017; Smith Cross, 2017). Even when, on August 10, 2017, the Ontario government announced that it would cover the cost of medical abortions for Ontario Health Insurance Plan (OHIP)-insured residents; barriers remained because few providers were trained to prescribe and provide Mifegymiso (Hudes, 2017; Ministry of Health and Long-Term Care, 2017).

Slowly, however, many provinces and providers have begun to increase the accessibility of Mifegymiso. For example, as of April 2017, only 5 abortion clinics across Canada and a few pharmacies were carrying the medication (Grant, 2017). However, as of June 2019, all 10 Canadian provinces and 2 of 3 territories (Northwest Territories and Yukon, not Nunavut) offer universal-coverage of Mifegymiso, and all provinces and territories provide access to Mifegymiso in at least one clinic (Action Canada for Sexual Health and Rights, 2019a; Weeks, 2019). While access to Mifegymiso in Canada has substantially improved over the past few years, other barriers and issues of access to abortion in Canada persist and include: social (Wiebe, Chalmers, & Yager, 2012), political (Kaposy 2009, 2010; Downie & Nassar, 2007), economic (Grant, 2017; Star Editorial Board, 2017) and historical (Stettner, 2013) factors. Research suggests that many Canadian women face a combination of barriers to abortion access, including geographical-economic-political barriers (Cano & Foster, 2016; Foster, LaRoche, El-Haddad, Degroot, & El-Mowafi, 2017; Sethna & Doull, 2013). These issues have been challenged by many advocates for women's health as ongoing issues of health equity and

reproductive health justice (Luna, 2011; MacQuarrie, 2016; Roberts, 2016; Smith, 2005; Stettner, 2016).

Available evidence from abortion clinics indicate that women of all ages access abortion services[1] and, among women who present for abortion services, motherhood is often part of their consideration for doing so, with women reporting that their expectations and experiences with motherhood often frame their conceptualizations and abortion decision-making (Wiebe et al., 2012). I was well aware, as a Public Health Nurse, how many social and structural factors, such as education and socioeconomic status, affect women's lives including their motherhood status and I was particularly interested in how women consider motherhood in relation to their abortion.

Rationale

There is a significant amount of literature addressing abortion in the political science, medical, and legal literature. However, despite the fact that abortion is a women's health issue, and nurses have been on the forefront of advocating for a range of women's health concerns (for example, homelessness and housing, lesbian, bisexual, transgender and queer [LBTQ] concerns, intimate partner violence) there is a paucity of nursing research about abortion (Trybulski, 2005, 2006a, 2006b). Among the studies exploring nursing and abortion, a majority focus on nurses' role in surgical and medical abortion care (Huntington, 2002; Lipp, 2008a, 2008b; McLemore & Levi, 2011; Tisdale, 1987). Few studies in the nursing literature have examined women's experiences with abortion (Aléx & Hammarström, 2004; McIntyre, Anderson, & McDonald, 2001; Timpson, 1996; Trybulski, 2005, 2006) and only one of these is a Canadian study (McIntyre et al., 2001).

[1] Women's ages and rates of abortion have remained stable for decades according to Wiebe et al. (2012).

Although access to abortion in Canada has been legal since 1969, many contemporary gaps remain in Canadian women's abilities to access both surgical and medical abortions (Cano & Foster, 2016; Foster et al., 2017; Kaposy, 2009, 2010; Sethna & Doull, 2013). There is a small body of primarily American literature suggesting that the social determinants of health, specifically that of gender, are relevant to mothers' decision-making, rationale, and women's experience of abortion (Abrams, 2015; Jones, Frohwirth, & Moore, 2008; Wiebe et al., 2012; Williams & Shames, 2004).

Because nurses work with diverse women across their lifespans and need to understand diverse women's health issues in order to provide optimal care for them, I believe it is important for nurses to better understand the experiences of women who have abortions in Canada, and the relevance of access with the advent of medical abortion in Canada. There are implications for nurses' ability to provide holistic care for individual women as well as implications for the role of nursing in effecting reproductive justice.

Research Aims and Questions

The primary aim of this research is to explore women's experiences of abortion and understand access to care in this context and the contemporary Canadian landscape of medical and surgical options. Second, I aim to explore and better understand how motherhood features in women's stories and experiences of abortion. The research questions are:

1. What are Canadian women's stories of abortion?
2. How do women experience access to abortion?
3. What factors influence women's access to abortion?
4. How is motherhood relevant to women's stories of abortion?

Importance of Study

Nursing occupies a privileged position in bearing witness to human experiences (Falk-Rafael, 2005b). Giving voice to human experiences is an important component of nurses' roles (Falk-Rafael, 2005b). Therefore, studying women's abortion experiences is an important area of nursing research. Moreover, reproductive and sexual health are considered research priority areas of study in women's health (Maher & Mohammed, 2015). Given the limited nursing literature on abortion, and also abortion in literature on motherhood, as well as the changing Canadian landscape for abortion, this study will contribute to an understanding of women's experiences of abortion and access to care, providing a snapshot of women's experiences in the current landscape. Through this study, I make visible how women experience their reproductive health, validate their stories and offer insight into their interactions with nurses, health care workers, and systems of health care. Using nursing voices, combined with a critical feminist view and foregrounding the abortion context, I aim to critically examine the contexts and social structures in place in diverse women's lives and consider implications for nursing to improve the wellbeing and everyday lives of women.

Terminology

The terms mother and abortion appear throughout this study. Because these terms can be defined in various ways, for clarity, the definitions used in the study are:

Mother. A common dictionary definition of mother is 'the female parent of a child' (Oxford Learner's Dictionary, n. d.). However, from a feminist perspective, the term "mother" may have many meanings, including: biological, adopted, grandmother, step-mother, auntie, god-mother, or sister-as-mother-figure, among many others. For this reason, and for the purpose

of this study aligned with a critical feminist perspective, I used women's self-definitions as mothers.

The Institution of "Motherhood". The notion of motherhood as it aligns with the Institution of "Motherhood", or the upheld social expectations for mothers as a group, differs from a woman's individual mothering experiences (Coulter, 2010; Lovett, 2010; O'Reilly, 2004a). Related terms in include: pronatalism and antinatalism and will be elaborated upon in the thesis.

Abortion. Similarly, the term abortion may have many meanings for many women. For the purposes of this study, I defined abortion as the 'deliberate termination of a human pregnancy' (Oxford English Dictionary, n. d.). I use the concept of deliberate termination (contrasted with miscarriage, for example) to reflect Canadian social values and the decriminalization of abortion in 1988, making abortion a legal option.

This chapter provided some background to set the context for this study, and its importance in this particular time and space in Canada. In the next chapter I look at some of the abortion literature from various disciplines in order to provide a more fulsome background on abortion experience of women and to set the stage for my particular study.

Chapter 2: Literature Review

In this chapter I provide an overview of the literature on abortion, as it related to my study on the experiences of Canadian women with abortion. Beginning with the history of the women's health movement, I set the context for the history of abortion in Canada. Drawing from interdisciplinary literature in social science, law, and women's studies, I looked at literature centering women's experiences of abortion. I also took an in-depth look at the abortion literature in nursing and the ways in which abortion has, and has not been, studied.

History of the Women's Health Movement

Abortion has a long history, both locally and globally, with strong ties to the state of control of women's reproductive health. Before the second wave of feminism, women were routinely penalized for vying for control over their own lives, including their reproductive health (Ehrenreich & English, 2010). For example, women were accused for being sexual; of being organized; and, of having so-called magical powers affecting health (Ehrenreich & English, 2010). Women faced severe consequences for not adhering to men's control, including the violation of their bodies, through stripping, torture, violence (Ehrenreich & English, 2010).

While progress was made in women's bodily autonomy in the post-witch hunt era, it was in the 1960s in America that women's thinking began to shift dramatically towards women's autonomy and self-control. One fundamental women's group famously joined together in 1969, in what would later become *The Boston Women's Health Book Collective* – an organization formed to bring knowledge about women's bodies to women themselves (Boston Women's Health Book Collective, 2011). Their publication – "Our Bodies, Ourselves" has been in production ever since, and includes honest and plain-language information about women's

health, including substantial and detailed sections on sexuality and abortion (Boston Women's Health Book Collective, 2011).

"Our Bodies Ourselves" has been at the forefront of challenging medicine's longstanding control over many women's bodies and reproduction (Boston Women's Health Book Collective, 2011). Nursing, despite its status as a female-dominated profession, has aligned with medical orthodoxy that considered physicians the most appropriate group to control and oversee women's health. That is, until freestanding clinics for birth and abortion emerged with the Women's Movement. This was a key impetus for contemporary health care providers' greater support for women's control of their bodies and lives, and thus reproductive health justice.

To understand the context of abortion and motherhood in Canada, a review of the literature on abortion was undertaken. The literature in this review is contextualized in relation to women's control over their bodies, their lives, and overall, reproductive rights and justice.

International and National Context of Abortion

Internationally, the abortion landscape and accessibility to abortion varies widely. Outside of developed countries, access to safe abortion remains especially dire—for example, estimates suggest that every year 25 million performed abortions are unsafe, with nearly all of these occurring in developing countries (Ganatra et al., 2017; World Health Organization (WHO), 2018). Even within the developed world, there are variations in laws and access to abortion, or types of abortion. For example, Ireland only recently legalized abortion on December 20, 2018 (*RTE*, 2018). In contrast, France has had access to abortion since 1975, and access to the abortion pill since 1988, while most European nations and the United States began offering the abortion pill about twenty years ago, around the year 2000 (Jones & Henshaw, 2002). Still, and despite the calls for change from the World Health Organization, many abortion

restrictions persist around the world, for example the inclusion of "mandatory waiting periods"—the time between when a woman expresses a need for abortion, and her acquisition of it—often a few days, to a few weeks in duration (Berer, 2017; WHO, 2015). For example, France, despite its early adoption of the abortion pill in 1988, only eliminated such waiting periods in 2015 (Berer, 2017). Recent contemporary policy and political changes in Canada and the United States are likely affecting abortion worldwide. In 2017, the United States government made the decision to defund global abortion programs, while, conversely, in Canada, Prime Minister Justin Trudeau committed up to $20 million dollars toward global abortion-related reproductive health projects within a larger commitment of $650 million toward women's global reproductive health and rights (Blanchfield, 2017; Government of Canada, 2019; Harris, 2017). In the United States, support for abortions varies significantly by state, with four states being extremely supportive or supportive of abortion, and twenty-one states considered hostile or extremely hostile to abortion (Guttmacher Institute, 2018). Recently, there has been a surge in laws attempting to ban abortion in several States, most aiming to limit abortion beyond 6 weeks—to a timeframe when, as Nash (2019) argues, before most people know they are pregnant. So far, none of these bans have been enacted, but there is concern that this law will make its way all the way to the Supreme Court, where the country's top Justices may enact the ban (Nash, 2019).

Abortion History in Canada

Abortion in Canada, as elsewhere, has a storied and living history. Until 1969, abortion in Canada was illegal. Abortion was decriminalized in Canada in 1969, but at that time, the procedure still required consent of three doctors and was only permitted in hospital settings (Rodgers & Downie, 2006). It wasn't until 1988 (with support from Dr. Henry Morgentaler, a

prominent abortion activist and physician who had been performing abortions (at that time illegally), that abortion laws were struck down, in effect, legalizing abortion in Canada (Gordon & Thain, 2018; Rodgers & Downie, 2006). In 1988, abortion became a woman's choice, no longer requiring any such permission from physicians (Rodgers & Downie, 2006). However, while abortion became legal in 1988, it did not automatically guarantee access or social acceptability (Gordon & Thain, 2018; Rodgers & Downie, 2006). Some of these issues persist today. The literature pertaining to these areas as it informs the current study will be explored in detail in subsequent sections.

Abortion in Canada (Statistics)

Abortion is an experience relevant for women in Canada, as it is elsewhere in the world. It is estimated that somewhere between one in three to one in four women in Canada will have an abortion in her lifetime (Dunn & Cook, 2014; Norman, 2012). Some research suggests that 27% of all Canadian women in their reproductive years today will have an abortion in her lifetime (Norman, 2012), while Dunn and Cook (2014) suggest that number is closer to 33%. These numbers represent a rough estimate, due in part to the fact that abortion reporting has been inconsistent across and within provinces over time (Abortion Rights Coalition of Canada, 2019).

Because of incomplete reporting of abortions, it is suggested that estimates of gross numbers of abortions likely underestimate Canadian abortion prevalence (Abortion Rights Coalition of Canada, 2019; Canadian Institute for Health Information, 2014). Nevertheless, the most recent available data, from 2017, show that 94,030 elective abortions were reported in Canada that year (Canadian Institute for Health Information, 2017). This number, even if it represents an underestimate, represents a significant number of abortions experienced by women

in Canada. Moreover, the reported abortion data indicate a steady number of abortions year after year in Canada, with the following recorded number of abortions:

Table 1

Canadian Abortion Data - Total # of Abortions Reported 2014-2017

Year	Rate
2014	81,897
2015	100,104
2016	97, 764
2017	94, 030

Canadian Institute for Health Information (2014, 2015, 2016, 2017)

Access

Despite the Canadian government's recognition that abortion is a fundamental right and need, access to abortions have been problematic for Canadian women (Cano & Foster, 2016; Foster et al., 2017; Sethna & Doull, 2013; Vogel, 2015). The availability, dissemination, and access to Mifegymiso made Canadian headlines throughout the course of my research (see, for example: Endemann, 2019; Grant, 2017, 2019; Hudes, 2017; Ibrahim, 2018; Leeder, 2018; Smith Cross, 2017; Zingel, 2019). In a country such as Canada, physical and geographical barriers have a significant impact on women's ability to access abortion services (Cano & Foster, 2016; Foster et al., 2017; Sethna & Doull, 2013; Vogel, 2015). Those living in rural settings face significant challenges to abortion access, including access issues related to inadequate health care staffing levels to perform surgical abortions (Cano & Foster, 2016; Dressler, Maughn, Soon, & Norman, 2013; Norman, Soon, Maughn, & Dressler, 2013). Access to abortion services can mean access to various things, for example: available staff, available physician training,

willingness to perform abortions, and prevalence of conscientious objection (Cano & Foster, 2016; Kaposy, 2010; Shaw & Downie, 2014). One notable exception to the somewhat historically scarce and sporadic access to abortion across Canada is in the province of Quebec, which has *half* of Canada's entire surgical abortion facilities and has had dedicated funds allocated to establish abortion clinics in underserved areas since 1970 (Vogel, 2015). The impact of physical and geographical barriers cannot be understated as a current, ongoing issue for many Canadian women (Cano & Foster, 2016; Foster et al., 2017). Other barriers facing women who have abortions are the related costs such as gas, hotel, childcare, lost work time, and the barriers that these may create for women, particularly young women of low socioeconomic status (Cano & Foster, 2016; Sethna & Doull, 2013).

Around the world, access to abortion has been facilitated by offering the abortion pill (Winikoff & Sheldon, 2012). The abortion pill was first made available in France and China in the 1980s, and has since shown to be a discreet method of abortion, allowing women to access abortions without necessitating surgical facilities and therefore, less reliance on the medical system (Winikoff & Sheldon, 2012). Nevertheless, getting medications approved in Canada first requires a manufacturer to submit an application to Health Canada, a process that has significant costs and time involved (CBC News, 2019). Due to Canada's relatively small population size, the Canadian market was long considered too small and a significant financial risk for manufacturers to enter (CBC News, 2019; Winikoff & Sheldon, 2012). However, in July 2015, the abortion pill was approved (CBC News, 2019).

Even though Health Canada's approval began in July 2015, only since January 2017 has Mifegymiso been available to women for use. The launch in Canada was slow, with many providers first waiting for provincial drug coverage announcements before taking the mandatory

training program to prescribe Mifegymiso (Grant, 2017). Access was also slowed by Health Canada's original approval restriction that limited the dispensing and sale of Mifegymiso to physician-prescribers only (Grant, 2017). Thus, Mifegymiso was not originally available for pharmacists to dispense, although this has since changed with significant advocacy efforts on the part of the Ontario Pharmacists Association and the Ontario Medical Association calling for improved Mifegymiso access (Grant, 2017; Ministry of Health and Long-Term Care, 2017). In spring 2017, British Columbia's College of Pharmacists started encouraging their members to dispense Mifegymiso despite Health Canada's restriction, and Ontario officially followed suit, with joint August 10, 2017 announcements, allowing pharmacists to dispense Mifegymiso, and also that the province would cover the cost of Mifegymiso for OHIP-covered residents (Grant, 2017; Ministry of Health and Long-Term Care, 2017). However, at that point in time, obtaining Mifegymiso still required physicians willing to prescribe it, and did not automatically guarantee availability of the drug at patients' local pharmacies (Hudes, 2017). However, much has progressed since 2017. Currently, in 2019, women in all provinces and territories have access to Mifegymiso in at least one part of the province/territory, although individual access still varies significantly (Action Canada for Sexual Health and Rights, 2019a).

Abortion Discourses

While physical, resource, and staffing issues present components of access issues for women seeking abortions, anti-abortion discourses are also believed to play a significant role in reinforcing traditional views of femininity and sexuality and to limit access to abortion through the perpetuation and persistence of such discourses (Bourgeois, 2014). Anti-abortion discourses are relevant to the current study insofar as gendered anti-abortion messaging may serve to limit women's access and impede women's autonomy to make the best decision for themselves.

In a world increasingly reliant on the Internet and social media for information, the information contained on the web with respect to anti-abortion messaging can have a significant impact. Saurette and Gordon (2013) performed a discourse analysis on anti-abortion dialogue in Canada by examining anti-abortion blogs, websites, and MP statements and found the abortion language in these texts changed significantly over the past 40 years, so much so that anti-abortion messaging now resembles pro-feminist rhetoric (Saurette and Gordon, 2013). According to Saurette and Gordon (2013, 2015), this imitation feminist discourse purposefully conceals anti-feminist values and may be confusing for women. (For example, see REAL Women of Canada (2016), and their use of their website tagline "A pro-family women's movement" http://www.realwomenofcanada.ca/.)

Abortion protests have historically been a site where anti-abortion language and discourse were often pronounced. Wu and Arthur (2010) believe targeted abortion protests and messaging are fundamentally unfair and unjust, and pose the question: "What other medical procedure allows for people to be bullied when they get their procedure?" Although street-level protests against abortion were once the main type of protest, sites of protest have changed in contemporary times, for example, to the online environment (Saurette & Gordon, 2015). Moreover, many provinces have enacted "bubble zones" around abortion clinics, restricting abortion protesting activity (CBC News, 2018; Bellefontaine, 2018). Ontario, for example, enacted a bubble zone of at least 50-meters from any abortion clinic as part of the Safe Access to Abortion Services Act in October 2017 (CBC News, 2018). This occurred after numerous reports of clinic users being harassed and, in one case, a woman being spat on by a protester when entering an Ottawa clinic (Mah, 2017). Other provinces have enacted similar laws, most allowing, in addition, the ability for abortion sites other than clinics (e.g.

hospitals/pharmacies/walk-in clinics) to also apply for 50-150-meter protest-free zones (Mah, 2017). Recently, and possibly due to the restrictions imposed against clinic abortion protesting, anti-abortion messages have been delivered differently – for example, via advertising space on public transit buses (Endemann, 2019; Mallick, 2017).

Discourses were also problematic for women who were not sure where to look for information on accessing abortion. In a research presentation at the University of McGill's 2018 Abortion Beyond Bounds conference in Montreal, Quebec, Katelyn Mitchell's research with women in Southern Alberta identified that a lack of credible information about abortion access on the Internet was filled by anti-abortion organizations, such as Pregnancy Care Centres. In such cases, abortion discourse was described as misleading and misinforming to women (Mitchell, 2018, personal communication). At New Brunswick's only freestanding abortion clinic, Clinic 554, a Right-to-Life clinic has long-operated next door (Ibrahim, 2018). According to Clinic 554 director Valerie Edelman, it is easy for women to mistake [Right-to-Life] for [Clinic 554] and she adds that Right-to-Life keeps no right-to-life signage at their entrance, and instead goes by the public-facing name, *Women's Care Clinic* (Ibrahim, 2018).

In addition to abortion messaging, several authors argue that the way in which abortions are discussed are problematic. Weitz, Moore, Gordon, & Adler (2008) suggest that socially, a common message about abortion is to "make abortions rare". A focus on making abortions rare can imply that abortions are occurring more often than they should and can create false goals for providers to reduce abortion rates, instead of improving access to abortions (Weitz et al., 2008). Similarly, the term "elective abortion" is considered to be a misnomer to many, given that abortions are not generally considered elective but rather necessary, by women, for any number

of reasons (from parenting living children, to school or work priorities, to family crises, etc.) (Janiak & Goldberg, 2016).

Institution of Motherhood: Pronatalism and Antinatalism

Russo states that pronatalism, a social and cultural "institution of motherhood" obsession with maternity, works to make "the idea of a woman being something other than primarily mother and wife… literally unthinkable" (as cited in Speier, 2004; O'Reilly, 2004a). Pronatalism perpetuates the ideological norm of motherhood and the desire for motherhood (Moore, 2018). In this normative view, aligned with O'Reilly's (2004a) framing of the "institution of motherhood", the dominance of patriarchy is embedded in all social institutions (e.g., health and legal systems, and "normalized" nuclear family structure) and shape many men's and women's "taken for granted" knowledge. Patriarchy privileges the authority of male voices and decision making, devaluing women's voices, except as they support males, and discount women's knowledge, and their ability to exercise agency and have authority over their lives. For instance, lesbian mothers are considered to reject the male in their family structures; similarly, abortion, is the rejection of the male seed. Thus, with abortion, in the context of pronatalist discourses of motherhood, women are often considered to be in defiance of mothering when they choose an abortion (Jones et al., 2008; Williams & Shames, 2004). According to Abrams (2015) social acceptability of abortions is low, with many women who choose abortion being described as "abandoning their fertility" and abandoning their "feminine ways of being". In fact, in other countries outside of Canada, abortions remain illegal, except, (and sometimes not) in selectively limited situations, such as rape (Abrams, 2015).

However, feminist mothering practices have also been documented that shift dominant motherhood ideas, and instead move discourses of mothering away from deeply embedded

pronatalist discourses (MacDonnell, 2006; O'Reilly, 2004a). Challenging motherhood ideologies serves to challenge patriarchal authority that operates to control gender confines and the ideal of the "good mother", instead allowing women to self-define motherhood for themselves (MacDonnell, 2006; O'Reilly, 2004a). Practices such as these, that defy pronatalism, are sometimes known as anti-natalist.[2]

Becoming a mother is complicated by the fact that motherhood is not always a respected endeavour, motherhood is challenging, and the conditions of motherhood are poor for many women (Williams & Shames, 2004). Di Lapi (1989) used a gender lens to show how assumptions about "appropriate" motherhood are deeply embedded in society. She highlighted resources available to diverse mothers to show how some mothers are seen as deserving of resources and others, marginalized by sexual orientation or disability for instance, are not. The current research suggests assumptions about appropriate femininity and motherhood may be persisting. While only a select few studies exist exploring mothers' experience with abortion, these studies suggest that women who had abortions did so based on their desires to be good mothers to their existing children (Jones et al., 2008; Williams & Shames, 2004). Similarly, having an abortion to delay motherhood was often done in the case of relationship concerns, including but not limited to those in which abuse was a factor (Wiebe et al., 2012). As Wiebe et al. (2012) describe, women are often waiting to bring their children into the world and raise families within the context of a healthy relationship. Williams and Shames (2004) note motherhood's many contradictions, including that motherhood is simultaneously considered a

[2] Note that this term has also been used in alternate way such as to describe how society controls certain group's lives and reproductive health, such as the forceful way in which some women are discouraged from parenting and the imposition of reproductive control on these women. For example, abortion coercion, and the sterilization of Indigenous and disabled women (see Boyer & Bartlett, 2017; Moore, 2018; Di Lapi, 1989). See Chapter 1: Terminology for definitions of the use of pronatalism and anti-natalism in this work.

most important social job, yet is unpaid, and that workplaces are often family-hostile, offering little flexibility to mothers (Williams & Shames, 2004).

According to Williams & Shames (2004) there is a lack of research linking women with the conditions they face as mothers, and reproductive rights. Problematical to improving the lives of mothers, research on mothering has long been considered outside of the scope of feminist research and has been marginalized in the university setting (Kawash, 2011). For example, the leading association and publication on motherhood—the Association for Research on Mothering and a journal by the same name—led by Dr. Andrea O'Reilly, began at York University in 1998, but was forced to close May 1, 2010 for financial reasons (Kawash, 2011). Shortly thereafter, O'Reilly reopened the center as a not-for-profit and the journal under a new name: Motherhood Initiative for Research and Community Involvement (MIRCI), but without support of the university (Kawash, 2011; Motherhood Initiative for Research and Community Involvement, 2019).

Women's Experiences of Abortion

The experiences faced by women after an abortion are explored to some extent in the women's studies, sociology, medical, health, and nursing literature (Aléx & Hammarström, 2004; Cano & Foster, 2016; Dennis, Manski, & Blanchard, 2015; Dykes, Slade, & Haywood, 2011; Foster et al., 2017; Kimport, Perrucci, & Weitz, 2012; McIntyre et al., 2001; Sethna & Doull, 2013; Trybulski, 2005, 2006a; Vogel et al., 2016; Weitz et al., 2008). This also included a narrative review study (Lie, Robson & May, 2008) of 18 qualitative studies of experiences of abortion that revealed three main themes in the literature on abortion experiences between 1998 and 2007, including: choices centered on available resources; women's emotional experiences; and, the environment/context of abortion care and interactions with health care providers.

Research about women's experiences commonly centered on women's feelings subsequent to an abortion. A nursing/medicine descriptive feminist study in Sweden by Aléx and Hammarström (2004) studied five women one month after their abortions and found that women often experienced feelings of ambivalence (including that of relief, but also some reflection on their pregnancy and "how far along they would have been"). Support (both positive and negative) from women's mothers, friends, partners and health care staff was found to influence women's emotional experiences connected to their abortions (Aléx and Hammarström, 2004). Research by Dykes et al. (2011) explored the feelings of women at menopause who had abortions earlier in life. Dykes et al. (2011) identified persistent emotional themes including: sadness, regret, guilt, personal judgment, development of resilience, coming to terms with their decisions, and persistent conflicted thoughts. In the narrative review study, Lie, Robson & May (2008) found that women who were well-informed and supported in advance of their abortions, had good emotional and psychosocial outcomes after abortion.

Nursing research about women's experiences by Trybulski (2005) explored women's experiences 15 years post-abortion in an effort to discover the long-term effects of abortion. Trybulski (2005) found that women described their abortion experiences as "being caught up in the moment"; "being betrayed by their bodies and birth control"; "being a very personal and private experience"; "being a persistent memory" of either relief or feelings of a lost child; "being a repressed memory"; "being an experience which disrupted many aspects of lives including their relationships"; and "being an experience they made sense of over time".

While relief and feelings of persistent loss may be among the most commonly cited emotions experienced by women who have abortions, there is also an emerging recognition, including in the aforementioned studies, of the complicatedness of abortion experiences, and the

recognition that emotional responses are multiple and varied (Weitz et al., 2008). Weitz et al. (2008) suggest that a lack of awareness of the complex emotional responses of women can, in fact, undermine women's health promotion, and therefore, argues for allied health care providers to give validating responses to women who have or have had abortions.

Wiebe, Najafi, Soheil, & Kamani (2011) conducted a quantitative study on Muslim women having abortions in Canada, about their attitudes, beliefs and experiences. Women in that study disclosed a lack of support in Muslim women's communities for abortion. Although study questions were centered on anxiousness, depression, and guilt, Wiebe et al. (2011) also found that Muslim women experienced a range of psychological experiences associated with an abortion. In addition, the study also found that Muslim women who held more anti-choice beliefs and/or religious conviction were more likely to have more guilt than Muslim women who did not share those beliefs (Wiebe et al., 2011).

Given the significance of support often noted by women experiencing abortion, Kimport et al. (2011), studied the merits of abortion support talklines and suggested that regardless of women's experiences post-abortion, women need receptive spaces to share their diverse experiences and emotions. Kimport et al. (2011) suggest that emotional support should be available for women at any time after an abortion, regardless of how much time has elapsed since their abortion.

A 2015 qualitative study from the State of Massachusetts, looked at low-income women's experiences accessing abortion, and found that most women described having fairly good access to abortion care (Dennis et al., 2015). However, despite Massachusetts being a fairly "progressive state", where insurance coverage included abortion-costs, 33% did not have insurance coverage (Dennis et al., 2015). For those who wanted to apply, experiences of a "lag

period" between applying and being granted insurance were common (Dennis et al., 2015). Most women in the study found the care they received to be high quality and compassionate, but still a large minority of women expressed some level of dissatisfaction with the "routineness" of the care they received (Dennis et al., 2015). Dennis et al. (2015) also described the following experiences of women in their study: women who paid for their abortion to avoid having it appear on their parent's insurance claims, and the challenging experiences of two immigrant women, who were unfamiliar with waiting periods, and were under the false impression that abortion would be a same-day service (Dennis et al, 2015).

More recently, significantly more has been published in the health sciences about Canadian women's abortion experiences. Vogel et al. (2016) conducted 176 interviews with Canadian women between 2012-2015 in Alberta, Manitoba, New Brunswick, Ontario and Quebec who had had abortions, and asked them, retrospectively, about their knowledge of and interest in mifepristone in relation to their abortion experiences. Most women in the study expressed interest in mifepristone (56%) and provided the following reasons: the perceived "ease" of the process, the privacy, the reduced waiting times, being able to complete the procedure at home, and the "less invasive" nature of medical abortion (Vogel et al., 2016). Women in the study also valued choice and highlighted the importance of choice in abortion care (Vogel et al., 2016).

Health science research by Cano and Foster (2016) looked at the experiences of women having abortions in Yukon Territory after 2005 using qualitative interviews. They found that abortion access for women in Yukon Territory is a complicated process including multiple clinic visits and significant wait times (Cano & Foster, 2016). Participants expressed wanting to know what would happen in the abortion process and considered knowledge about the process to be

significantly important in their abortion access experiences (Cano & Foster, 2016). Cano and Foster (2016) saw opportunities for telepractice and Mifegymiso to expand access to abortion in Yukon Territory.

Research by Foster et al. (2017) explored the experiences of 33 women living in New Brunswick who had abortions between 2009-2014, and found that women's abortion experiences included: significant travel costs, numerous visits to clinics, experiences of conscientious refusal from physicians, and significant wait times which sometimes had impact on their ability to access abortion within permitted provincial gestational-limit timeframes (Foster et al., 2017). The study also reported on one participant's attempt at self-inducing an abortion using vitamins and herbs, and then, when that did not work, trying to get mifepristone sent to her (Foster et al., 2017)

Recent Canadian publications also include two academic anthologies: *Without Apology: Writing on Abortion in Canada* (Stettner, 2016) and *Pregnancy Loss: Feminist writings on Abortion, Miscarriage, and Stillbirth* (Lind & Deveau, 2017). These anthologies and articles centralize the stories of Canadian women who have had abortions and serve to enhance the academic body of knowledge of Canadian women's abortion experiences.

The experiences of women who have abortion still largely represent the experiences of women who are white. However, there is evidence of the inclusion of other races and ethnicities in the recent Canadian literature. Wiebe et al. (2011) studied the psychological experiences of 53 Muslim women. And, in published Canadian studies by Cano and Foster (2015), Vogel et al. (2016), and Foster et al. (2017) approximately n=5 (of 16), n=41 (of 174), and n=5 (of 33) participants, respectively, identified as non-white.

Nursing and Abortion

Historically, nurses and other health care providers have been a part of the reproductive health movements but were not always advocates for women's full reproductive health. For example, Margaret Sanger is well-known for initiating the birth control movement in North America in the 1920s (Saurette & Gordon, 2015). However, the birth control movement discourse largely prioritized family planning, which also had ties to the eugenics movements (Saurette & Gordon, 2015), thus, creating a movement that liberated some women, while further oppressing other, often more marginalized women. Saurette and Gordon (2015) also note that nurses and advocates of the early birth control movement were silent on the issue of abortion and tended to see contraception as the solution for women's reproductive and mothering emancipation.

The early birth control movement shapes nursing's history. Along with nursing's early ties as a handmaiden to medicine, and nursing's imposition of middle-class values on working class women, nurses acting as advocates for the women's health movement was not immediate, and in fact, some remain critical of nursing's collective performance advocating for reproductive health (Ehrenreich & English, 2010). That is not to say that nurses are inactive—in fact, nurses have taken up women's health concerns for example, advocating for a modernized sexual health curriculum with a focus on reproductive rights embedded in human rights (RNAO, 2018).

Although nurses are involved in caring for women across the lifespan, including women's reproductive years, I found a paucity of nursing literature written about women's experience with abortion. While nursing literature may be largely silent on issues related to abortion, nurses have been visible advocates and researchers in other areas of health, for example, advocates for lesbian, gay, bisexual, transgender, queer, plus (LGBTQ+) populations

and vulnerable populations such as the homeless (RNAO, 2004, 2007). Given the relative silence in nursing literature, the experiences of women with abortion is an area of research identified as in need for further study by nurses (Tanner, 2006; Trybulski, 2006b).

There is some research about abortion in nursing, and the majority of nursing-based research in abortion care has centered the role of nurses working in abortion care. A 2011 review of the United States and United Kingdom literature by McLemore & Levi (2011) entitled "Nurses and care of women seeking abortions, 1971-2011" summarizes much of the literature in this area. In their review, McLemore & Levi (2011) highlight the many skills of nurses in caring for women experiencing an unintended pregnancy, including; the assessment of women's emotional responses, coping skills, and social resources as they cared for women experiencing an unintended pregnancy. The review also demonstrates nurses' awareness of women's often inadequate socioeconomic resources for childrearing (McLemore & Levi, 2011).

A study included in the aforementioned review of literature is Lipp's (2008a) feminist grounded theory study. Lipp (2008a) examined the behaviour and perceived roles of nurses and midwives working with women undergoing pregnancy termination. This study explored nurses' knowledge and skills in facilitating the decision with women, appreciating women's contexts, and assisting women with coping with termination (Lipp, 2008a). While the study used a feminist/woman-centered approach, it did not explore women's or mothers' experiences directly, but did so through nurses and midwives. Lipp (2008b) also reviewed the literature on abortion health care provider attitudes and found that attitudes towards abortion among health care providers varied widely, suggesting greater attention to health care provider attitudes could improve the quality of care for women undergoing abortion.

Huntington (2002) used both feminist and nursing knowledge to explore nursing's role in abortion provision with women experiencing second trimester termination. Huntington (2002) argued for the integration of feminist knowledge to enhance nurses' abilities to cope with the experience of caring for women having an abortion. Huntington (2002) considers the centralizing of women and their experiences (both nurses and the women who have abortions) as a way to create and sustain the intimacy of abortion experiences and to enhance the quality of care in second-trimester abortion work.

Sallie Tisdale, a nurse and author, wrote a nursing memoir of her time spent working in an abortion clinic. As she tells her story and perspective on abortion, she writes "each abortion is a measure of our failure to protect, to nourish our own"; and that, "in abortion, the absolute must always be tempered by the contextual, because both are real, both valid, both hard" (Tisdale, 1987, p. 66). Tisdale reflects as well, on the feminist position in favour of abortion, remembering that "the women who have the fewest choices of all, exercise their right to abortion the most" (Tisdale, 1987, p. 70).

Of the literature in nursing examining women's experiences, two qualitative studies that address women's experience with abortion stand out as particularly relevant to the current study (Trybulski, 2005; McIntryre et al., 2001). As previously discussed, Trybulski (2005) examined the characteristics of white, middle-class, well-educated American women who had abortions, at least fifteen years earlier, using a phenomenological approach. In her findings, Trybulski (2005) identified nine themes (reviewed earlier), finding many complex emotions continuing to shape the present-day experiences of those women interviewed. Motherhood was not examined in detail or specifically as part of Trybulski's (2005) study, however, women often reflected on lost motherhood. As one participant noted: "Sometimes I often wonder what my first child would

have been like… sometimes I, I look at girls who are 15, 14 and I just look at them and say that is the age my child would been if I hadn't aborted." (Trybulski, 2005). Another participant felt the need to "make amends to her lost children", and symbolically sponsored two children through World Vision (Trybulski, 2005, p. 572).

Trybulski (2005) concludes that the abortion experience is a longstanding memory for many women. In her summary, Trybulski makes the case that women are willing to share their emotions on this topic and hopes to encourage broader listening among health care providers. While Trybulski's (2005) study examines women's experiences with abortion, as a phenomenological study, it does not explore women's experiences of abortion from a feminist or critical lens, nor does it look specifically at mothers' experiences of abortion.

In another nursing article, McIntyre et al. (2001) examined Canadian women's experiences with abortion, also using a phenomenological approach. In the study by McIntyre et al. (2001), fourteen women aged 19-44 were interviewed and their cultural narratives were analyzed alongside women's narratives of abortion. McIntyre et al. (2001) found women's stories included themes of isolation, difficulty determining whom they could trust to share their abortion experience with, feeling silenced from sharing their story, and tension between their feelings and the realities they were living. While the study is Canadian and explores women's experiences with abortion alongside cultural meanings attributed to abortion, the study was conducted over fifteen years ago and the experiences of mothers are not specifically examined.

In summary, the nursing literature of abortion examines nurses' roles as caring providers for women experiencing abortions, crediting nurses' abilities to help women cope with abortions, including nurses' skilled abilities at therapeutic relationships (McLemore & Levi, 2011; Lipp, 2008). Opportunities identified in the literature for nursing skill development in abortion care

included: increasing contextual awareness of women's situations, centralizing women's experiences, and integrating knowledge (Huntington, 2002; Tisdale, 1987). The research approaches used to examine nurses' roles in abortion care were varied and included: a literature review (McLemore & Levi, 2011), a grounded theory (Lipp, 2008a), an expert opinion piece/literature review (Huntington, 2002), and a memoire (Tisdale, 1987). When examining women's experiences with abortion, the nursing literature in this area used mainly phenomenology to examine women's experiences (Trybulski, 2005, 2006; McIntyre, 2001). Themes from phenomenological nursing research explore the silencing of women, their complex emotions, including tension and isolation, and the sometimes-long-lasting experience of abortion (Trybulski, 2005, 2006a; McIntryre, 2001).

Reproductive Rights, Social Justice, and Public Policy

Women's rights to sexual health, including abortion access, are contemporary global issues. Currently, worldwide, 45% of all abortions are considered unsafe; largely in countries where women have few abortion rights (Ganatra et al., 2017; World Health Organization (WHO), 2018). In Canada, where abortion rights have been achieved since 1988, and the abortion debate "closed", there is however, recent evidence of attempts to erode Canadian women's sexual and reproductive rights. For example, in May 2019 in Ontario, three MPPs spoke at an anti-abortion rally and vowed "to make abortion unthinkable in [their] lifetime" (Clementson, 2019). Perhaps not surprisingly, due to the far-reaching implications of abortion, and the myriad of ways in which women's reproductive health can be researched, a variety of disciplines contribute to abortion in the reproductive rights and social justice literature.

Stettner (2013) looked at the history of the abortion movement and linked the abortion caravan with anti-Vietnam war activism. Stettner (2013) provides history about social justice

movements and how one movement can spur the development of other social justice movements. Stettner (2013) also reminds us that the abortion caravan chose Mothers' Day 1970 as a symbolic day to remember women who suffered from illegal abortions.

Kaposy (2009) examined public policy around the funding of abortions in Canada. In contrast to the general and historical argument that abortions be funded because they are "medically necessary", Kaposy (2009) argues for the social necessity of publicly funded abortions. By suggesting the social necessity of abortion, Kaposy (2009) suggests a de-medicalization, and suggests that attention be paid to the social implications of not providing abortion when it is sought.

The social necessity of abortion is also highlighted in Medoff (2016) who looked at the relationship between United States abortion policy and child well-being (using an 18-indicator child wellbeing tool) among several States. In his research Medoff (2016) found that the States with the most antiabortion policies were correlated with States with the poorest infant/child well-being. Thus, it is suggested that the states encouraging births do not, in fact, support healthy childhood development. Medoff's (2016) research suggests the importance of connecting maternal health with reproductive health and exploring these issues together.

In the social work literature, Shaw (2013) has argued for birth activism and abortion activism to come together under one lens of reproductive justice. Shaw (2013) suggests that too often abortion activism is considered separate from birth activism/the de-medicalization of birth. Shaw (2013) argues that both causes are reproductive justice causes and both are critical to women's health and social justice and should be mutually considered. Shaw's (2013) observation suggests support for a study that examines mothers' experiences with abortion.

Reproductive justice literature is thought to be particular salient in addressing the often-controversial notions of abortions for reasons of sex selection. In fact, medical doctors have written about their hopes that inequality in sex selection abortion studies will be used to "develop policies to eliminate prenatal sex selection in Canada" (Yasseen III & Lacaze-Masmonteil, 2016). But pro-choice advocates contest that, through a reproductive justice lens, all abortions need to be valid—that women do not need additional intensive scrutiny in to their lives, particularly women of colour—who would likely receive the most scrutiny from such a ban, and moreover, that sex selection bans would do nothing to eliminate the root causes and perpetuation of sexist and gender-biased social norms (Vogel, 2012). In a similar way, debates about and against abortions for fetal anomaly can potentially benefit from the adoption of a reproductive justice lens—a lens that considers the varied circumstances, oppressions, and barriers, or supports, and privileges of women's lives, and accepts the limitations of women's "choices", and therefore centralizes women's own, personal, and subjective decisions about whether or not to have a child expected to have a fetal anomaly (Saurette & Gordon, 2015).

Summary of Key Themes in the Literature

In this chapter I provided some international context to abortion before examining Canadian history of abortion and discussing fundamental Canadian abortion statistics. I then discussed the contemporary need for abortion in Canada. I explored access issues in Canada for women and the literature on abortion discourses. Following this, I explored the limited literature on motherhood and abortion. I then focused on the abortion literature, including the few select nursing studies on this topic, which have tended to focus on women's experiences of isolation and silence, and women's complex emotional experiences of abortion. I looked at the literature

on abortion access, social justice, and reproductive rights and justice, literature that largely originates from legal, sociological, and women's studies.

This literature review provided rationale for a study on Canadian women's contemporary abortion access experiences. Although in Canada the decriminalization of abortion happened 50 years ago, and the legalization of abortion happened 30 years ago, contemporary issues of access to abortion remain salient in this country today, including access restrictions to Mifegymiso (Endemann, 2019; Erdman, 2008; Grant, 2017, 2019; Hudes, 2017; Ibrahim, 2018; Kaposy, 2010; Leeder, 2018; Smith Cross, 2017; Zingel, 2019), persistent geographical barriers (Sethna & Doull, 2013; Cano & Foster, 2016; Foster et al., 2017), and inabilities to adequately staff abortion services across the country (Shaw & Downie, 2014; Kaposy, 2010). Anti-abortion messaging has also continued in prominent ways (Mitchell, 2018; Saurette & Gordon, 2013, 2015).

Although there is some nursing literature examining abortion, the nursing literature examined primarily the experiences of nurses (McLemore & Levi, 2011; Lipp, 2008a, Huntington, 2002; Tisdale, 1987). Less is known in the nursing literature about the experiences of women who have abortions, although there is indication that women's experiences with abortion are complex, sometimes emotional, and often a longstanding memory for women who have experienced abortion (Aléx and Hammarström, 2004; Trybulski, 2005). There is also indication that women often felt silenced from sharing their story of abortion, and thus felt isolated in their experience trying to navigate whom they could trust (McIntyre et al., 2001). Although some information is known about women's experiences with abortion from a nursing lens, larger contextual factors influencing women's experiences have not been detailed in Canadian nursing research. In particular, how women understand and make meaning of abortion

in their context of their lives amidst a background of the institution of motherhood and how this is understood in society has implications for all women, and, is the inquiry of this study.

Chapter 3: Methodology

In this chapter, I present the theoretical frameworks that informed this study. I then present some underlying assumptions used in the study and the research methods, ethics and processes to ensure study rigour and plans for dissemination.

Theoretical Frameworks

Given the purpose of the study is to explore women's experiences with abortion access in detail and richness, both a critical feminist lens and narrative methodology were chosen as means to study women's abortion experiences. I situate myself in a critical paradigm and consider how gender and other dynamics of power are relevant to the framing and undertaking of the study throughout the research process, including the collection of women's stories, the analysis of findings, and implications for action relevant to women's stories.

Narrative methodology. As a simple definition, narrative approaches use stories to understand realities (Bruner, 1987; Duffy, 2012; Kelly & Howie, 2007). Narrative methodology has been considered particularly useful in showcasing how people make sense of particular events and actions in their lives, especially what Reissman (1993) refers to as "consequential events" and what Haydon and van der Riet (2017) term "the influence of the ordeal itself" (p. 85). Unlike many qualitative methods, where bits and pieces of narration may be taken out of context, a central component of narrative methodology is to preserve the sociality, the temporality, and the spaciality of narratives (Clandinin & Connelly, 2000; Clandinin, 2013; Haydon & van der Riet, 2017). A narrative approach was chosen because this approach specifically studies the story of an individual; in other words, it gives voice to issues, through stories, told by individuals (Bruner, 1987; Creswell & Poth, 2017; Duffy, 2012; Kelly & Howie, 2007; Pitre, Kushner, Raine, & Hegadoren, 2013). I believe that the narrative approach is an

approach well-suited to the sensitive study of abortion experiences. I agree with Baker and De Robertis (2005) who critique the limitations of political abortion dialogue, and favour instead, women's own voices and their stories of abortion.

In this study, a narrative approach was taken to examine women's stories of abortion access—with an underlying assumption that the stories women tell and the ways in which they are constructed have meaning. According to the Personal Narratives Group (1989), narratives are suitable for feminist-based research to show: "a construction of gendered self-identity, the relationship between the individual and society in the creation and perpetuation of gender norms, and the dynamics of power relations between women and men" (p. 5). Sometimes referred to as "subtle inequalities" specifically gendered experiences such as gender norms and expectations can be revealed through women's narratives (Personal Narratives Group, 1989). Moreover, narratives may reinforce social gender roles for women, or they may show a resistance of dominant gender roles, opening new possibilities for viewing women's experiences. Narratives also make visible individuals stories in relation to institutional and cultural stories (Clandinin, 2013). From there, narratives can also make visible where there is a need for enhanced social action (Clandinin, 2013).

Multiple narratives are reported in this research, which follows an intention to study a variety of narratives in an attempt to avoid what Chimamanda Ngozi Adichie calls "the danger of a single story" (Adichie, 2009). Feminists have been criticized for essentializing some women's stories, taking these to represent all women's stories (Scheer, Stevens, & Mkandawire-Valhmu, 2016). It is recognized that women have many different stories, originating from multiple intersections of life stories, all of which contribute to people's experiences and the narratives they share about such experiences (Van Herk, Smith, & Andrew, 2010). Furthermore, narratives

provide opportunities to look at dominant as well as counter and contrasting narratives. The presentation of counter narratives is relevant in minimizing essentialist ways of writing about women's experiences, as well as being particularly relevant to those who might identify with marginalized narratives and say, as Hall and Carlson (2016) suggest, "Yes, this one' story sounds more like me, my life and struggle" (p. 207).

Critical feminist theory. Building on the work of several researchers who saw the fit between feminism and nursing in the 1980s and 1990s (see for example, Bunting and Campbell, 1990; Chinn & Wheeler, 1985; MacPherson, 1983; Webb, 1984) several nursing researchers have aligned feminist research and human science nursing (see for example: Burton, 2016; Falk-Rafael, 2005a; Kagan, Smith, Richard Cowling, & Chinn, 2009; MacDonnell & Andrews, 2006; MacDonnell, 2014).

To understand women's stories of abortion, this study used a critical feminist approach to centre gender in the interview, interpretation, and retelling of the women's stories (Pitre et al., 2013). While many aspects of life may be considered influential in women's stories, this feminist approach will look specifically at how "gender and a gendered social order shape women's lives and their consciousness" (Polit & Beck, 2012, p. 508) as it pertains to women's experiences with abortion. Women's experiences are known to be, at times, subjugated in ways that are difficult to ascertain without examining the detailed nuances of women's experiences through women's own words (Hesse-Biber, 2014b).

Feminist research is also concerned with the intersections of gender with other lenses such as sexual orientation, ethnicity, ability, and class (Hesse-Biber, 2014b). Known as intersectionality theory, various oppressions and ideologies, including, for example, racism, heterosexism, and classism operate and are known to have direct influence on the

marginalization of people in various co-occurring ways, such that gender is not generally the only, nor most important marginalization (Hall & Carlson, 2016). An "[i]ntersectional feminist critique advocates gender and experiences of all women in content and methods with recognition of differences in race, class, and sexual [orientation]" (Kagan et al., 2009, p. 69; Wesp, 2018). Feminist theory invites multiplicities, ambiguity, and paradoxical understanding, recognizing that women bring multiple subjectivities to their experiences and recognizes that a diversity of human experiences honours the many, multiple, personal ways of knowing and experiencing the world (Campbell & Bunting, 1991; Creswell & Poth, 2017; Hesse-Biber, 2014a, 2014b; Longo & Dunphy, 2012; Sprague, 2016).

A critical feminist analysis examines the contexts and meanings of larger social, political, and economic factors associated with women's experiences (Hesse-Biber, 2014b). Feminist methodology includes reflections on the nature and origins of social differences and situated privilege (MacDonnell, 2014). Deep reflection on the processes by which individuals and communities are privileged, marginalized, or rendered invisible—in specific contexts, with implications for access—can reveal greater (macro) (as well as meso and micro) inequities embedded in systems, organizations, policies, and social norms (MacDonnell, 2014). By examining women's stories and considering their individual stories alongside intersections of social, economic, political, and historical facets, women's individual experiences become contextualized within social landscapes. Identifying and critiquing context can contribute to a deeper understanding of experiences of health and illness and can help nurses to better understand the forces shaping the health experiences of their communities and reflect on the nature and origins of social differences and situated privilege (Longo and Dunphy, 2012; MacDonnell, 2014).

The application of critical feminist theories, rooted in their critique and analysis of social injustices, provides a platform for what nursing theorists Chinn & Kramer (2015) call "emancipatory knowing". Emancipatory knowing is defined as the ability to critically reflect on the social, cultural, and political realities, and to develop an understanding of how those realities came to be (Chinn & Kramer, 2015). In turn, emancipatory knowing is what provides and shapes nursing knowledge and action in social justice nursing practice (Chinn, 2017; Falk-Rafael & Betker, 2012; Wesp, 2018). Action is central to critical feminist analysis, where it is understood that action is necessary in order to change social, political, and economic forces and/or to change thinking around those processes. With its emancipatory and action-oriented framework, critical feminist approaches can serve to amplify the "emancipatory power of nursing theory" by bringing to the foreground historical and sociopolitical contexts that may go unnoticed using other theoretical frameworks (Georges, 2005).

Reflexivity, or "reflexive praxis" is key to feminist research methodology, and involves the documentation of social location, and the roles played by researchers in co-creating data, and constructing knowledge (Doucet & Mauthner, 2005). It means an active reflection on how the personal, interpersonal, institutional, theoretical, epistemological, and ontological biases operate in the research, analysis and interpretation phases of research (Doucet & Mauthner, 2005). In other words, reflexivity is about taking into account the context of the research study of both participants and myself as researcher, by examining: the time period in which the research occurs, and how history, politics, and economy shape issues and experiences heard (MacDonnell, 2014).

As researcher, I also recognize that I have my own narratives and operate using my own norms and assumption about the world. In and of themselves, assumptions are not inherently

bad, but what is necessary is to be open to other ways of seeing the world, and to question how my own ways of experience may be sustaining the status quo. I recognize too that I also need to be open to the ways in which the social norms I hold can be problematized or called into question. I also recognize that even as someone who is invested in women's health research, and who holds pro-choice values, that I hold personal narratives about what it means to have reproductive access, and ideas about what it means to have an abortion. I recognize as well that I hold not only personal space but also a professional space as a Public Health Nurse, and that this space also carries with it certain longstanding narratives, for example, heterosexist (MacDonnell, 2001) and biomedical (Paterson, Scala, & Sokolon, 2014) reproductive health narratives.

In a review of trends in feminist nursing research, Im (2010) notes that feminist research often included research questions highlighting and addressing themes of oppression, discrimination and empowerment—and suggests the utility of feminism in addressing women's oppressed experiences in healthcare systems. Similarly, it has been suggested that a feminist focus is especially helpful to maintain and protect the potentially vulnerable reproductive rights of women (hooks, 2000). Thus, I believe there is a strong case for studying women's experience with abortion, and examining, in detail, women's experiences, with the use of critical feminist theoretical frameworks.

Assumptions

The philosophical and theoretical assumptions I have made in this study are influenced by my experiences in the world, in other words, my worldview situated in a critical feminist paradigm. In making my ontological, epistemological, axiological, and methodological assumptions known, I am setting the stage for the approaches I will take in my study. Although various feminist paradigms exist, I have chosen a critical feminist paradigm to frame the current

study, given my desire to critically examine aspects of gender, and social, historical, political, structural and economic forces; and, how these may intersect and impact the experiences of women (and mothers) who have abortions (Creswell & Poth, 2017; Hesse-Biber, 2014a, 2014b; Sprague, 2016). In choosing a critical feminist paradigm, I can address the social, historical, political, and structural aspects affecting or implicit in women's experiences. In doing so, I aim to examine the power relations, and to examine how these structures of power may influence women's behaviours and experiences (Hesse-Biber, 2014a). In critical feminist research, I am setting the stage for transformative critical feminist research, meaning that I sought not only to interpret the experiences of women, but also to critique and present opportunities to advance social justice to improve the experiences of Canadian women (Hesse-Biber, 2014a).

Ontology. Ontological assumptions refer to one's understanding of the nature of reality (Creswell & Poth, 2017). In this research, I approached the work through an understanding that reality is subjective and also contextual and shifting. I considered that historical, social, and economic factors influenced reality. Thus, an ontological assumption of this study is that the individual experiences shared by participants represent these particular women's realities at a certain point in time (2015-2018) and in certain settings (urban settings in Canada) (Creswell & Poth, 2017). From my ontological position, knowledge about Canadian women's experiences was gained by exploring their diverse, situated stories, at this particular time. In this study, my aim was not to generalize, but rather to individualize women's stories about their experiences accessing abortion and to use a critical feminist analysis to explore some possible social constructions of women's experiences.

Epistemology. The knowledge and perspectives I captured in this study were the subjective and individualized experiences of women who have had abortions. It was my

assumption, based on theoretical frameworks I used, that there are multiple, diverse experiences, and that there is not one universalizing subjective experience of abortion. Rather, I understood that there are many diverse experiences, including some experiences that may seem to contradict others. It is my belief that the subjective, diverse, and contradicting experiences are a necessary aspect of telling mothers' stories of abortion.

Axiology. In this qualitative, feminist, narrative research study, it was not my intent to isolate myself as researcher from the women with whom I conducted research. Instead, I made my values and social position clear because of the possibility that my position as a researcher may have influenced the knowledge and experience I brought to the study, the directions I took in the study, my analysis, and how I chose to disseminate the knowledge. At the time of writing, I am a female, white, middle-class Public Health Nurse, who has been working in the field for nearly 8 years. I have focused my work in public health largely in Family Health and Sexual Health programs. I also have studied and obtained an undergraduate degree in Women's Studies. I see reproductive health as an area of health that crosses the chasm of maternal and sexual health, as well as nursing and women's studies, and is, based on my experiences, a critically important aspect of health for many women. I have discussed abortion with many of my clients in my practice as a nurse. In many of these conversations, abortion as a reproductive health option was explored, and through these conversations, I developed a personal interest in discovering the stories of women who have had abortions. Many women's stories are stories that I had not read about in nursing school, or in the nursing literature, or in practice. Nonetheless, I believe women's stories and caring for women aligns justifiable within the caring and social justice theories underlying much of nursing's work (Chinn, 2017; Falk-Rafael & Betker, 2012; Watson, 2008). In choosing this study and focusing it on women's experiences of abortion, I

convey my values as a feminist nurse committed to social justice, including supporting women's full rights to reproductive health, including abortion. I recognize too, that my identification as a white, middle-class, 35 year old female Registered Nurse (RN), living in the GTA, with undergraduate training, and no identification with any priority groups, nor as a mother, nor someone who has yet had an abortion, is a potential influencer in the ways that women responded, or felt comfortable responding in the interview (Hesse-Biber, 2014a). In taking this axiological approach, I do not hide my positionality, but instead I reflect throughout this research and analysis, on how my own positionality may have had influence.

Participant Sampling

The purpose of this study was to explore women's contemporary experiences with abortion, using purposive and convenience sampling. Inclusion criteria were Canadian women who had:

-Elective abortions in otherwise healthy pregnancies at any point in the pregnancy between May 2015 and May 2018

-Either by surgical or medical abortion pill (Mifegymiso)

-Between 18-49 years of age

-English-speaking

Exclusion criteria were:

-Reproductive losses of miscarriage, fetal death, or still birth, in the absence of elective abortion

-Self-identification of having any other traumatic, psychological, or other ailment considered to be debilitating and/or with the potential to interfere harmfully in recounting an abortion experience

-Any previous relationship with the researcher

A combination of convenience and purposive sampling was used to recruit women who had abortions by liaising with abortion clinic providers and their networks. Initially, I used convenience sampling to include women in the sample by way of abortion clinics who had agreed to post my flyer. I followed this up with purposive sampling to aim for a diverse sample, and, where possible, to include women who self-identified as mothers, and participants who self-identified as having had a medical abortion (Polit & Beck, 2012). Although mothers were not targeted exclusively in the 2nd round of recruitment, 5/7 participants identify as mothers. This sample therefore defies the often-stereotypical representation of women who have abortions, often considered to be the experience of women who are exclusively "young and promiscuous" (Wershler, 2016).

Select demographic criteria were collected, including: age, age at abortion(s), highest educational attainment, partial postal code, self-identified identity with priority group, and type of abortion (medical or surgical). This information was used to assess and differentiate the sample since I aimed for a diverse sample of participants. I required participants to be able to speak and read English for reasons of feasibility, given limited funds available for interpretation services and concerns with respect to ensuring privacy in the context of this graduate research study.

Participants were selected who self-identified as meeting the inclusion and exclusion criteria and who were willing to share their stories and engage in the process of research. Knowing that the nature of narrative research is extensive, and data is typically rich, the number of participants was limited to seven. My original goal was for 4-6 women in order to assess for a rich understanding. After recruiting six participants, a seventh was included who identified a recent abortion, along with a past teen pregnancy and who gave her son up for adoption. This

was a story I determined would add to the spectrum of reproductive experiences in my study and add to what I had thus far heard in my research. Following this 7th participant and taking into consideration the large amount and rich interview data I had already collected, I stopped recruiting.

Recruitment

Recruitment describes the work done to obtain the sample of participants. Only after ethics approval did I begin recruiting participants. Participants were recruited in Canada using convenience and purposive sampling through my professional networks linked to abortion clinics, initially limited to the Greater Toronto Area (Polit and Beck, 2012). This was done with the help of clinics who agreed to post my recruitment poster (Appendix A). After five months, and only one recruited participant, an amendment was submitted and subsequently approved by the Office of Research Ethics at York University. This amendment expanded the recruitment method to include abortion clinics and providers outside of my professional network, and broadened to include not only mothers, but any woman who had an abortion within the past 3 years (up from 2 years). Notably, whereas I originally recruited mothers, the final interview question was phrased Q4: Can you tell me what it means to be a mother and to have an abortion? After the approval amendment in June 2018, this question was revised to: Q4: Can you tell me about your thoughts about motherhood and its challenges? Or, what it means, to you, to be a mother and to have an abortion?

My recruitment strategy was, in part, informed by the GTA-based sexual health clinic professional networks I developed through my work in public health nursing practice. Participant recruitment took into account the sensitivities surrounding abortion and recruited only in settings considered safe for women having abortions. Recruitment was originally limited

to two agreeable local [Greater Toronto Area (GTA)] abortion clinics via poster recruitment and in-person recruitment. As agreed with the clinics, recruitment posters were sent to the clinics, and posted in clinic recovery areas, or similar areas (Appendix A). (The clinic recovery area is an area within the abortion clinics where women who have surgical abortions recover, have a drink or snack, and await their ride home.) An option for recruitment included an in-person day(s) for me to attend clinics and provide information or accept same-day referrals to my study. However, this in-person option for recruitment was not pursued based on follow-up communication with abortion clinics. Nonetheless, an in-person script was developed for such purposes (Appendix B). Recruitment assistance was ultimately requested by e-mail and also by word of mouth, to Canadian abortion providers, along with the approved poster attachment (Appendix A).

Data Collection Methods

Interviews were the main data collection method used in this study. Feminist research and the collection of women's stories as data often supports the use of interviews (DeVault & Gross, 2012). Data was collected between May 2018 and September 2018. I developed in-person and verbal informed consent forms (Appendix C, Appendix D), a demographic questionnaire (Appendix E), and a semi-structured interview guide (Appendix F). Interviews took place either in-person, or were conducted virtually using zoom or skype technology, where both interviewer and interviewee were visible to each other. Appendix H includes revisions made to appendices with the study amendment.

Interviews were 40-90-minutes in duration, with women often sharing significant details about their abortion experiences. Open-ended questions allowed women to share their experiences of abortion in ways that felt comfortable to them and to stop, pause, or discontinue the conversation at any time. I personally transcribed each interview as soon as possible after the

interview. In attending to data transcription, I spent a considerable amount of time scrutinizing and assessing my transcription drafts such that the focus of my analysis became more clear (Reissman, 1993). In this way, I attended, as best as possible, to maintain the original intonation, pauses, and particular moments of emphasis that I heard in the interview. I also recognized that my own lens may have impacted the way I heard women's stories, and so, I used reflection, and sought clarification throughout the interview, if any information was ambiguous (DeVault & Gross, 2012). I invited participants to reach out to me after to the interview if they would like to clarify any piece of the interview. I also agreed to share my interpretation of the interview and transcripts of the data individually with interested participants. Throughout the research process, I maintained detailed research notes which were reflections on the research, its progress, and my own learnings (DeVault & Gross, 2012).

Ethics

Before study initiation, I sought and received ethics approval from York University's Ethics Review Board (Polit & Beck, 2012). Because of the historically contentious nature of abortion, ethical considerations were of great importance to the study's overall progress, interpretation, and meaning. I considered the potential vulnerability of the participants. As such, I took precautions and made necessary modifications in order to ensure the safety and wellbeing of the participants. This included ensuring: that participants were aware that the study was voluntary; compensating women even if they did not complete the study; maintaining confidentiality of individuals and organizations; and having counselling referral information readily available to all participants.

I sought consent from participants voluntarily using an informed consent form (Appendix C), and assured participants that their participation could be withdrawn at any time without

penalty. I advised participants of the potential risks of participating in the study, including the possibility that discussing abortion access may provoke undesirable feelings of discomfort, or grief. Given this, participants were encouraged to tell their stories in ways that they felt comfortable. Abortion counselling talk lines and mental health crisis support phone numbers were made available to all participants. Based on my own nursing assessment, at no time did I feel it necessary to make any referrals to counselling, or stop the interview based on the burdensomeness of the study, nor at any time did any of the participants request stopping the interview.

The participants may have seen a few benefits to participating in the study. For example, participation in this study may have allowed women to tell aspects of their stories that they may not have shared otherwise. This research may have presented a novel opportunity for women to share potentially rarely told reproductive experiences. Women were also provided with a $20 honorarium in the form of a coffee card, plus an additional $20 (cash or coffee card) to cover costs of childcare and/or transportation to attend the interview.

Protecting participant and organizational (abortion clinic) confidentiality were important features of this study. Participant data was protected (encrypted and password protected materials), and pseudonyms (assigned by me at the time of transcription) were used to identify participants. Names of health care facilities as well as health care providers and/or names of other people were also anonymized in order to safeguard the identity of participants. I personally transcribed all seven interviews which also added to my ability to protect participant data. Paper consent forms were stored in a locked file. Recordings of transcripts were deleted immediately after the interviews were transcribed. Data on the USB, and paper informed consents are being

stored in a locked cabinet in my personal files for 5 years (until September 2023) at which point these files will be destroyed as per York University policy.

Research interviews took place at a mutually convenient and agreed upon time and location for participants and myself, and was an attempt to honour women's spaces and the spaces in which women felt comfortable to share their stories. This included four Skype/Zoom interviews and three in-person interviews, with sites including: a coffee shop, a library terrace, and a participant's home. One participant requested that I conduct the virtual interview while she walked home from work, based on the fact that she "did most of her best thinking while walking." I assessed all sites prior to beginning the interview and considered the safety of both the participants and researcher. In the case of the interview in a coffee shop, both myself and the participant agreed to use a code word for abortion, in order to maintain additional client privacy and discretion.

Role of Researcher

My role as researcher was to collect the stories from mothers and to handle these stories with the utmost care so as not to breach women's trust and confidence. It was also my role to sit with women and to listen to their stories and interact with women in ways that made it possible for them to share their stories. As suggested by Reissman (1993), the researcher's job is to invite the telling of stories and narratives from participants with the use of questions that open-up the research topic and allow for telling. An interview guide (four semi-structured questions) (Appendix F) were used to facilitate the telling, and ultimately, for the participants to guide the development of meaning. I relied heavily on building trust and developing close interactions to do so (Im, 2010). Attempting also to be transparent, I disclosed my public health nursing background, and the intent of the research to participants. I saw my role as necessitating

openness, flexibility, kindness, caring, and sensitivity to the participants, and respecting the courage that they brought in sharing their stories with me. To that end, I also sought clarification of narratives and/or meanings that were unclear to me throughout the interview in a conscious attempt at giving authentic voice to women's stories (Hesse-Biber, 2014a). The research equally had an effect on me, as I was not a bystander of the research process, but rather I was a part of the process. Knowing that my own identity and background could affect the research process, I strove to maintain reflexivity in my research practice as I conducted the interviews by reflecting on my own experience, and jotting notes about the ways in which my own assumptions were being challenged throughout my research process (Polit & Beck, 2012).

Data Analysis

Data collection and data analysis were iterative (Clandinin, 2013). In practical terms, I used what Creswell & Poth (2017) refer to as a data spiral approach, meaning that I first audio-recorded data narratives, then I transcribed these audio recordings in a word document. Following data transcription, I read the data for emerging ideas, noting specific emphasis and pivotal moments (often turning points, epiphanies, and particularities raised by the participants) by making notes in margins and using reflection (Clandinin, 2013; Creswell & Poth, 2017; Reissman, 1993). Data analysis began early in my research process. As I collected data, I made notes about possible analyses, and about patterns and contradictions I saw emerging in participants' stories. In first analysing the research data, I considered the pivotal narratives as distinct bits (or, as Downey and Clandinin (2010) suggest, as "chunks of a broken mirror") that then provided me multiple new ways to retell women's stories (as cited in Clandinin, 2013, p. 48). I amalgamated notes into themes and sub-themes, making interpretations between themes (Creswell & Poth, 2017). As I progressed in my analysis, I returned several times to and from

the data, and considered many recurrent, notable, and alternate options for analysis. To compose the final text, I returned to my study questions, and the personal, practical, and social justifications consistent with my chosen methodologies—e.g. a critical feminist approach (Clandinin, 2013). Specifically, I also attended to issues of power and gender in my critical feminist analysis—for example, by exploring multiple and alternative interpretations of women's narratives around control and autonomy (Pitre et al., 2013).

Drawing from the meanings that were made visible in the themes and subthemes, I then analyzed the situatedness of women's stories—for instance, what made these themes sensible—for example, in what contexts did these ascribed meanings unfold? What social, cultural, and institutional contexts made these remarks and meanings possible? (Clandinin & Connelly, 2000; Reissman, 1993). For example, a major theme "Storying Women's Experiences" and subtheme "New perspectives on motherhood: Growth" were conceptualized through many multiple iterations and considerations that women shared about centering their identities, lived experiences, and learnings, often as mothers. These themes set the stage for the discussion of "Motherhood Journeys" in a subsequent chapter.

Rigour

Instead of adhering to a set of techniques to ensure quantitative rigour (commonly considered the techniques of validity, reliability, and generalizability), I instead followed Lincoln & Guba's (1985) approach to use a framework of quality to ensure diligence and attention to the study. Lincoln and Guba's (1985) approach uses techniques to evaluate study quality based on elements of credibility, dependability, confirmability, transferability, and authenticity, yet allows for "artfulness, versatility, and sensitivity to meaning and context that mark qualitative works of distinction" (Sandelowski, 1991, p. 1). It is, as Sandelowski (1991) writes, "fidelity to the spirit

of qualitative work" (p. 2). In this research, I aimed primarily to understand, interpret, and critically examine the experiences of participants and, like Denzin (1989) suggests, "the meanings of … experiences are best given by the persons who experience them; thus, a preoccupation with method, validation, reliability, generalizability, and theoretical relevance of the biographical method must be set aside in favor of a concern for meaning and interpretation" (p. 26). In this research, I attended to the trustworthiness of the data by attending to the authenticity of women's lives (Polit & Beck, 2012).

Limitations/Parameters

In this exploratory study, I sought to hear, understand, and report on women's experiences with abortion, specifically the intersections of motherhood with their abortion experiences. This study was exploratory because little research has been done on the topic of women's experiences of abortion in Canada from a nursing perspective. In this way, the study is not intended to be representative of all women who have abortion, but rather to provide a foundation and basis for further discussion about the experiences of women, including mothers, who have abortions, at a particular time period (2015-2018), during much transition in the Canadian abortion landscape and under much anticipation of increased abortion access, via the promises of Mifegymiso (Vogel et al., 2016).

This research was exploratory in nature, and the findings represent a small group of Canadian women (n=7). While this study is small, it presents some diversity among participants. This study included women of various ages, ranging from 20-44; two participants who identified as LGBTQ2S+, and one participant who identified as a visible minority (see Table 2, p. 51). Although attempts were made to increase the diversity of the sample, opportunities for maximum variation sampling were limited given the prolonged recruitment phase of the study, and time

limitations set for the completion of this research as part of a nursing thesis project. I made sampling attempts, where possible, to increase the variation sampling using women's self-identification. For example, some women provided their home city, or indicated specific details about their reproductive histories, such as one participants who claimed she had had a "unique experience", was helpful sampling information in expanding the diversity of participants, within the confines of my study.

Dissemination

I intend to share this research by communicating the study findings and interpretations, in an effort to contribute to enhancing women's abortion stories and to provide visibility of nursing contributions to enhancing abortion reproductive justice. To that end, I have presented earlier versions of this work at: The Abortion Beyond Bounds Conference at McGill University, in Montreal, Quebec (October 2018); the Community Health Nurses Conference in St. John, New Brunswick, (May 2019); the Social Justice Nursing Conference, York University, in Toronto, Ontario (June 2019); and the Guelph Sexuality Conference (June 2019). After thesis completion, I plan to publish the study, and subsequently share my work with individuals who have expressed interest in my professional networks.

Summary

In conducting this research, I held the intention of centering women's experiences in my research. My attention to women's narratives began with study conceptualization and continued through the use of critical feminist methodologies in all aspects this work. Critical feminist methodology sets my intentions and thinking through all the ethical, rigour, reflexivity and data collection processes and provides a focus from which to read the findings that follow in Chapter 4.

Chapter 4: Findings

The study findings are presented in this section. First, the demographics of seven women who were interviewed, are presented. Then, the results from women's narratives are presented and explored. In keeping with feminist and narrative methodology, I present a number of these themes using direct participant quotes to remain as close as possible to women's narratives.

Demographics

Participant demographics are presented as an important consideration in the context of understanding the study findings (Riessman, 1987). While remaining sensitive to the types and number of demographic questions asked, I collected voluntary information from each woman about their: age range, type of abortion, education, province/area, and whether women identified as belonging to any priority group (either lesbian, gay, bisexual, transgender, queer, Two-Spirit plus (LGTBQ2S+), living with a disability, a visible minority, or English as a second language). Women were also asked if they identified as a mother. This information is summarized in Table 2 using pseudonyms I assigned to the women. It is important to note that my own personal demographics may serve to influence the ways that women responded or felt comfortable responding in the interview.

Table 2. Participant Demographics

Name	**Age**	**Type of Abortion**	**Education**	**Priority Group Identity**	**Identify as mother**	**Province**	**Setting**
April	40-44	Surgical	Graduate degree	LGBTQ2S+	Yes	Ontario	Urban GTA
Benita	25-29	Medical	Undergraduate degree/ Diploma	Visible Minority	No	Ontario	Urban GTA
Chloe	25-29	Surgical	Some college/ university	LGBTQ2S+	No	Manitoba	Urban
Donna	35-39	Medical	Undergraduate degree/ Diploma	N/A	Yes	Ontario	Urban North
Emma	20-24	Surgical	Some college/ university	N/A	Yes	Alberta	Urban South
Fiona	35-39	Surgical	Undergraduate degree/ Diploma	N/A	Yes	Ontario	Urban GTA
Gina	40-45	Surgical	Undergraduate degree / diploma	N/A	Yes	Ontario	Urban GTA

Description of the Participants

The demographics show a well-educated sample of women, all who spoke English as a first language, and none who identified living with any disabilities. Five participants identified as heterosexual, and two participants were LGBTQ2S+-identified. One participant identified as a visible minority. Women's ages ranged from early twenties to mid-forties. All women in the

study were from urban settings. However, the cities they lived in varied significantly in size. Four of the participants were from the Greater Toronto Area (GTA), and the other three were from three separate cities in Manitoba, Northern Ontario, and Southern Alberta.

Two participants (April and Chloe) are considered key informants, as they described having some previous volunteering or work experience providing abortion counselling and care. This information was provided voluntarily as part of, and informing, their description of their experiences with abortion and was an unexpected finding of this study. The experiences as a volunteer or clinic counsellor provided their stories with some degree of baseline knowledge and understanding about abortion that may not have been present for other participants, which also contributed to a high degree of pre-held technical abortion knowledge, compared with other participants. This dual experience with abortion—both professional and personal—is evident in some passages throughout the findings.

Thematic Analysis Using Narrative and Critical Feminist Approaches

Several themes and subthemes stand out as prominent in the experiences described by women of accessing abortion in a contemporary Canadian context, between May 2015 and May 2018. I have identified three major themes and corresponding subthemes:

Theme 1: Storying Women's Experiences. This major theme included subthemes of: Pregnancy: Unexpectedness and impacts; Hard choices: Maintaining control; Pill versus surgical?; "It was almost like being back in your worst memory ever"; and, New perspectives on motherhood: Growth.

Theme 2: The Pivotal Nature of Support. This major theme included subthemes of: Emotional support; Instrumental support; Informational support; and, Appraisal support.

Theme 3: Factors Affecting Access to Optimal Care. This major theme included subthemes of: Navigation and timelines; Environments and unexpected costs; Culture of silence and stigma; and, Women's situatedness, privilege, and equity. The themes and subthemes represent micro, meso, and macro aspects of abortion experiences. Moreover, and central to this study, these themes and subthemes give voice to women's experiences.

Theme 1: Storying Women's Experiences

Finding oneself in need of an abortion is a personal situation. Although there are unique circumstances for each person who has an abortion, there are, I found, some commonalities across women's personal stories of abortion. In this section, I explore several subthemes related to the personal accounts of abortion including: what mattered to women- their reactions to pregnancy, their identities as women, their changing bodies, and their decision-making for abortion as well as contexts of their experiences. As women told their stories, it was evident that the abortion narrative was one aspect of their stories, but that their stories went beyond the abortion experience itself.

Pregnancy: Unexpectedness and impacts. This first subtheme details the unexpectedness as well as the impacts of women's unexpected pregnancies. Women described the unexpectedness of their pregnancies, especially when they had taken precautions to avoid pregnancy, and often framed their narratives around this unexpectedness. One participant summarized her experience by saying, "I never thought I would find myself in a position of having to make this decision." Another participant, Fiona, shared her level of unexpectedness and shock in saying: "I was really hoping that I was going to get my period. I was *really* hoping, and I ended up taking, I think, four pregnancy tests." For some women in the interview, their age and previous experiences with fertility contributed to their disbelief and the unexpectedness

of the situation. April described that she had had previous difficulty conceiving her daughter, and said, "I had [a child] I had to go through major fertility [treatments] with. It was not even registering that [pregnancy] was a possibility." Chloe remembers being meticulous at tracking her period and remembers laughing off being a week late to get her period. She recalls telling her friends, "There's no way! I'm so careful!" The unexpectedness of women's pregnancies set the foundations for their narratives, and how they told their stories of abortion.

There is, it seems, from women's narratives, a sense of unease expressed with the unexpectedness of their unwanted pregnancy. This unease exists, even though unexpected pregnancy remains a very common experience for women. The initial shock described by women also speaks to the idea of changing fertilities, and the less-talked about erratic nature of fertility as women enter different stages of their reproductive lives. In April's case, she describes being shocked at the state of being pregnant in her mid-forties, after having so much difficulty conceiving during her previous pregnancy. She seems to find her status as pregnant to be completely out of step with the way she had come to understand her fertility—as someone who had challenges conceiving. Gina, also in her forties, described shock at being pregnant at her age, after having just completed the bleeding phase of her cycle. For these women, even though they were peripherally aware of the changing nature of fertility with advancing maternal age, it was not something that they felt would happen in their lives.

Quickly women were faced with pregnancy symptoms, many unpleasant, which they spoke about in their interviews. Pregnancy literature often focuses on the joys of pregnancy. But, for a few participants, pregnancy was not an easy experience, and factored into their abortion experience. For most of the participants, pregnancy difficulties and discomforts were described as part of their experience. Women described being acutely aware of their bodies'

changing symptoms and associated physical manifestations. Two women prominently described the challenges of early pregnancy as being among the most difficult aspects of their abortion experience. They mentioned that the abortion experience itself was not difficult, nor traumatic, but that their pregnancies brought forward their biggest anxieties and fears. Donna, who described her previous pregnancy as "torture" and a sort of "pregnancy depression" mentioned, "I start vomiting right away, and heartburn immediately, and all the bad stuff that you could possibly have happen, always happens." Similarly, Fiona notes, "I was pregnant just long enough to experience the morning sickness, and the mood swings, and whatnot." Later, she continues, saying, "I felt so gross. I still had two kids to keep up with and I didn't want to cook anything! I was like, I am just going to lie down on the couch." Gina also felt the uneasiness in her body's changes with pregnancy. She describes, "I couldn't stand any of the changes, like I was really feeling things once I knew I was pregnant…. It doesn't take much, the changes to your breasts. I spent weeks taking a shower in a sports bra because I couldn't even look!" Gina also talked about not being able to think about anything aside from feeling sick and losing a lot of weight in the process. Gina summarizes her feelings by saying, "The pregnancy was hard but the abortion itself wasn't." Fiona found that not only did she have discomfort, but, knowing that she was planning an abortion, she described the additional layer of secrecy that she felt she had to maintain, stating: "And, you can't tell people why you're feeling… well, I guess I could. But, at work, I was trying not to tell anybody; trying to discreetly go to the bathroom to throw up!"

For some women, pregnancy considerations were tied to considerations about women's chronic illness and doubt about whether their chronic illness could support a pregnancy. Part of Chloe's conviction not to be a mother had to do with her chronic illness, and her longstanding beliefs about the capacity of her body to handle pregnancy. April, who dealt with chronic illness

and severe hemorrhoids, consulted with experts in the early weeks of her pregnancy. These professionals confirmed that April's physical ailments were likely to worsen with a subsequent pregnancy, if April were to carry her pregnancy to term. "I was told that with the pressure of pregnancy, that there's no way I would be able to manage them myself anymore, and that I'd be in excruciating pain for a lot of the pregnancy, and I would likely have to have surgery right after the baby was born." The experiences described by the women in this study suggest that continued pregnancies can provoke a range of undesirable health concerns for women, and that these symptoms factor into their living experiences and decision-making.

Despite the unexpectedness of pregnancy and some of the negative impacts, there are ways in which their pregnancies offered opportunities—particularly opportunities where women described enhanced connection to their reproductive health journeys. Benita, a woman between 25-29, describes the whole experience as new, and asserts, "I'd never done a pap test." Although it is unknown if Benita had a PAP done as part of her abortion experience, her comment suggests the abortion was an opportunity for her to learn about the PAP test, and for her to consider including it as part of her reproductive health care. For April, the unexpectedness of pregnancy provided an opportunity for her to be supported by her close circle of friends, who all came together to show their support for her in loving blanket ceremony, not long after her abortion.

Hard choices: Maintaining control. Once women came to know that they were pregnant, they often shifted focus to the deciding to have an abortion. For participants, the decision to have an abortion was often described as a hard choice, but one that they were willing to make in order to keep their lives within their control. Making the choice to have an abortion for many women was considered in the contexts of their lives. As one participant, Emma, described, "It's very hard to have an abortion. I love my daughter very much, and part of me

wished I could have carried my last pregnancy to term. But, I knew that I had to make a decision based on what was best for her… I had to focus on what she needed, which was, her mom to be able to focus on her." In her description, Emma expresses valuing her daughter above all else, and how this love—the love for her daughter and her responsibility and commitment to motherhood—provided the rationale for her abortion. Similarly, Fiona acknowledges the mutuality of the hard—but right—choice of abortion in her life. She says, "... this was the right decision for everyone, like, our entire family, and then sometimes when you're a mom you have to make a hard decision. And, that was probably the hardest decision I had to make, even though, not for one second did I think it was the wrong decision. It was still, —it's still tough."

Similarly, April felt that her decision was hard choice, and a decision that was made to maintain control over her family identity (a 2-child household). She recalls not wanting to have to make the decision to have an abortion, stating, "I so wanted to cling to the idea that [this] wasn't a viable pregnancy," but in the end, said that it felt best and less selfish to choose her family over the "little life." She recalls, however, that the decision was not easy, and potentially even made more difficult by the guilt she felt, having a number of supports in place—as a middle class, employed mother, with a supportive husband and large network of friends. She says, "I do have a lot more support than other people and I do have resources that other people don't have, and I do have a loving, supportive husband, and I do have great kids who would help out, and all of the stuff that I do have, actually made the decision harder to some extent." Unique to April's story is her decision to disclose her abortion to her children. In doing so, April described using the notion of a "hard choice" to explain the abortion decision-making process to her children. Speaking to the decision she made with her husband, April recalls sitting down with and telling her children, "We had to make a hard choice, and hard choices are hard to talk about. And,

choices, our choices always involve some degree of sadness; to choose one thing that would be really sacred and special, over another thing that is about health and wellness for us as a family." April's use of the term "hard choice" gives more context than "choice" alone and suggests the complex nature and the layered and profound components involved and underlining choice-making. She mentions too, having some reservation in telling her children, not wanting to burden them with her hard choice, but found that she was overwhelmed with the support she received from her children. She says that her children reminded her, "Babies are such hard work too! We wouldn't want to you to be sick, mom."

Women in the study expressed their specific desires to maintain control over their lives. Often, women expressed purposefully planning their reproductive lives—as childless, or as mothers of 1, 2, or 3 children—and this grounded their abortions decisions. For example, Chloe knew from a young age that she never wished to parent. She says, "Being pregnant was the worst thing that could happen to me, because I had spent my entire life trying to avoid that and had been advocating for a tubal [ligation] since I was fourteen." Chloe's strong convictions to remain childless were tied to her identity and way of life.

For Benita, the timing and circumstances for a pregnancy were not right—and she was clear that she wanted to be able to control the timing and circumstance of a pregnancy to a future time that would better suit her and her partner. In her narrative Benita reflects on her long-distance (overseas) relationship, and recounts, "[Having a child] is obviously not an option for us right now. So, we obviously talked about that. And, I said to him, like, no. Absolutely no. We're not in a situation that would be conducive, and this is not… I'm not saying forever, but, now is not a good time. We don't even live in the same country! Like, there are just way too

many complications and stuff. This is something that we have to think about and plan for it, not just, whoops, something happened!"

Upon learning of her recent pregnancy, some of Gina's friends suggested that perhaps she was being given a "second chance" to be a mother. Gina, who was in her forties when she conceived, and who had previously given up her son for adoption as a teenager, described how she considered her unexpected pregnancy as an opportunity for an altered motherhood identity but ultimately chose to maintain the life she had. She describes, "I tried to think through what it would mean to go through pregnancy again, but, I don't know how to describe it, I just couldn't stand it." She spoke about abortion as her way to maintain the familiar, expected, desire path in life, saying, "I think the real story of abortion is… that your life goes on."

Women considered the implications on control over the economic and environmental circumstances as they talked about their abortion decisions. Three participants describe, in detail, the physical circumstances of their lives, and not wanting their lives to change. Women spoke about wanting to keep their houses, and about not wanting to have to uproot to other, larger, homes if they had another child. Fiona reflects on her decision to have an abortion and highlights, "It was really a set of circumstances and having to change so much about our lives. And, I like our… this small house, and we live within our means… it's perfect!" Donna also felt that not having room for any more children influenced her decision greatly. She describes her house, with all its limitations, "…but, [having] 4 bedrooms! But, there's no room for another baby!" April also reflected on the conversation she had with her husband shortly after finding out about her pregnancy and coming to the realization that having another baby would mean that her children, who had been waiting for their own rooms for the longest time, wouldn't be able to. As participants came to their decisions about abortion, they scrutinized their own lives to varying

extents, and considered whether they had the will, and the means, to care for a child, or another child. Many women acted to maintain control over their current lives and avoid disruption to their physical spaces and economic futures.

A few women had lived experiences of poverty and others spoke about their limited financial means. April, Donna, and Fiona specifically spoke about their means and/or their experiences living in poverty, in their respective stories. They expressed a strong desire to keep their children's home spaces familiar and consistent and spoke about this stability as an influential aspect in their decisions to have abortions. Women seemed to want to live within their means, but also to protect their children, from being uprooted to larger, potentially less affordable households, and the financial stress that they perceived as likely to come from the addition of another child into their lives.

Donna, too, reflected on the connection between complete motherhood and her current abortion in a similar way. She said, "Even though I like the idea of having more kids, because I loved the baby stage, and toddlers are adorable, and, I enjoy my kids a lot. But, I was like, I can't do this again!" For Donna, the need for an abortion was made clear to her during the last pregnancy she carried to term, because of "how terrible of a mother" she felt was when she was pregnant with her third child. She remembers, "I basically laid on the couch as cried, and barfed, and was miserable. And, my little boys that were already here, they were just deprived of a … 34 weeks of being a good mom!"

Several women spoke of abortion connected to their desired, and complete, experiences having children—and again, wanting control over their motherhood experiences. Connecting her abortion experience with that of motherhood, Fiona said: "I love babies. I had babies. I had already done babies, so, I didn't feel like it was some sort of great loss. It just sounds so bad to

say it that way, but it wasn't a tragedy." Fiona's narrative suggests abortion as a way to maintain her vision of motherhood, and what was right for her. Fiona's narrative also suggests both her recognition and defiance of motherhood discourses when she says, "it just sounds so bad to say it that way, but it wasn't a tragedy." Although Fiona decided what was best for her and her family, she also seems aware of historical patriarchal discourses reflecting longstanding gendered social expectations of motherhood when she says, "it sounds so bad to say it that way." Abortion for Fiona was not "a tragedy", as it likely was not for other women, yet, Fiona's remark may speak to some of the ways in which mothers may be consciously or unconsciously affected by—and yet resist—dominant discourses. All of the participants demonstrate agency in their ability to control some aspect of their lives—and by making the decision to have an abortion. In these ways, women were active as participants in their lives, and demonstrate their own authorities, as opposed to being only subjects of paternalistic and patriarchal ways.

Pill versus surgical? The type of abortion women had was part of their experience and journey. However, not all women were given an easy choice to access the abortion pill. Both April and Gina, who had heard that medical abortions were available in Canada, were under the impression that the medical abortion would be a "simpler" process than having a surgical (aspiration) abortion. Both April and Gina were surprised to learn of the number of pre-and-post abortion appointments that were necessary for medical abortions and which ultimately deterred both women from having medical abortions, with both women opting for surgical abortions instead. Gina describes her initial reaction to the abortion pill: "At first, I loved it, because it sounded easier. Because, you take it home, and, I fear medical people based on my past experience (as a teenager, pregnant, and giving her son up for adoption)." Gina later said that her opinion changed after her friend, who had had a surgical abortion, told her that a surgical

abortion "only took 5 minutes." "To me, that was a game changer." April expressed similar confusion about simplified access to the abortion procedure and the abortion pill. She said, "I thought with medical abortion that I was just gonna be given medication that I could go home with [it]… and then they said, 'No, you actually have to come back three different times.'" April and Gina's experiences highlight some realities and barriers to Mifegymiso access that are not necessarily known to women when they first hear about the different types of abortion.

An important and timely consideration for this project was to address the experiences of women who have medical abortions with Mifegymiso. Two women in this study had such experiences. For all women, having agency and opportunity to choose the best type of abortion was deemed important. Of the seven participants, two participants, Benita and Donna, had medical abortions with Mifegymiso at home. The other women had surgical abortions in a clinic or hospital clinic setting. There was no consensus as to a preferred modality of abortion, however, the participants were keen to share how important it was for them to be able to choose the method of abortion they most preferred and control this aspect of their experience. Chloe, herself an abortion counsellor, reflected on choosing to have a surgical abortion. She said, "I fundamentally cannot understand why people would choose [a medical abortion], but then I hear from so many people that it was so much better for them. That - - the agency of choosing when to take it, [of] having someone with you…it provides more of an opportunity to connect with that physiological process of terminating." Chloe continued: "I just didn't want to be pregnant in the first place. So, I definitely didn't want to be confronted with that in my home." Benita, who had a medical abortion, takes the opposite view, but reinforces the theme of agency and the importance of choice. Benita reflects on searching out abortion clinics and finding one that offered medical abortions. She says, "And when I saw the two options, the pill option and the

other one. Obviously, I was like, pill option! 100% of the time!" Chloe summarizes the need for patient-centered care well in her summary: "I think that discussion between medical and surgical is such a potent reminder of why we need client-centered care. Because for me, [medical abortion is] my literal nightmare, and then for every person I talk to, you know, who's had positive experiences, is like, "I would never want to do it any other way!"

Even though both Benita and Donna convey their satisfaction and preference for medical over surgical abortion, they also share some more personal details of their medical abortion experiences, and some of the realities of a medical abortion at home. Donna elaborates on her experience having a home abortion. She says, "My little toddler was sitting beside me. So, I sat on the kitchen floor, kind of like, in discomfort. Not like cry--, but it was a pretty awful feeling pain-wise. And, then I could feel a larger lump, and I'm like, there's the fetal tissue. I knew when it came out. … So, then I picked it up and looked at it. And, I was like, …. garbage or toilet? And, I was like… toilet? So, I flushed it." Benita also described spending the entire afternoon and evening confined to her room and the bathroom due to the pain she experienced. She says, "The entire afternoon, up until early evening, I lay on my bed, went to the washroom, which was like 3 steps away, and went back to my bed, and I basically was there. I didn't eat anything. I don't know if I was supposed to eat or not." She said she also found herself worried about having enough pain medication and remembers feeling drowsy that evening—but, concludes, "That was that. I went through that night. And the next day, I went to work."

Chloe elaborates about the complexity of abortion—the way in which she finds it to be both such a personalized experience, but also a very medicalized one. Of her surgical abortion, she says, "It's interesting how medicalized that process it, and yet what a non-medical experience it is for so many folks." About her surgical abortion, she reflects, "even though it

was not considered a full-fledged medical experience [being in a women-centered clinic], she reflects, there's still medical instruments, there still hospital lighting… you feel the speculum, it feels… the physiological experience is so far removed from the spiritual experience."

These stories highlight women's desire for choice and control extends as well, to their choice in the methods they choose in their abortion experience. Chloe's story recognizes the ways in which abortion experiences are still widely medicalized processes. These stories also provide some insight into the practical components and considerations women encounter in their abortion experiences.

"It was almost like being back in your worst memory ever." In telling and recounting their abortion stories, women often made connections between their present reproductive experience and other previous reproductive experiences. Several women made connections to their past pregnancies, including Gina, Chloe, Donna, Emma and April whose links between their abortion and their past reproductive experiences seemed to be particularly central to their stories.

Chloe described the pain she endured being pregnant and having to access an abortion, after having been denied a tubal ligation for over eleven years, by several physicians. Chloe, who went on to have a tubal ligation one month after her abortion, said that, although she couldn't be completely sure, she felt strongly that it was only after she had her abortion, that her request for a tubal ligation came to be genuinely respected and ultimately granted. Chloe expressed not being able to separate her unwanted pregnancy and her abortion, from her decade-long quest to access a tubal ligation. She says, "My story with abortion is… I always talk about it, and think about it, and frame it as sort of a failing of the health care system…, in [denying] me a tubal ligation." Chloe's story raises a question of the extent to which women are able to

control their own reproductive lives and invites reflection about the extent to which people's full reproductive health care needs are being met.

For Gina, she tells her story with a lens looking to her past pregnancy, when she was a teenager. Gina says, "I had an experience of unplanned pregnancy when I was a teenager. I was 15 and gave my son up for adoption. So, that really had a huge impact on what happened this time … and I mention that because it really complicates my experience of pregnancy, ideas about motherhood, and everything!" Gina mentions that it was this teenage pregnancy that influenced many of her beliefs, and choices, including the use of fertility awareness methods as her preferred form of birth control, so that she would know "the very moment" any conception reoccurred. Moreover, for Gina, her recent pregnancy experience was closely tied with previous visceral memories from her teenage pregnancy. Gina says, "It was almost like being back in your worst memory ever. Even though the circumstances were really different." Of her teenage pregnancy, she remembers that people were "judgmental, and even well-intentioned adults, at that time, didn't know how to interact with you, when you were young and pregnant. And so, they either ignored the fact that you were in crisis or said the wrong things. And, my interactions with health folks at that time was… it wasn't very helpful." Gina links her abortion experience with her teenage pregnancy remembering the messages about abortion that she received as a young person. Of her abortion experience, she recalls, "I was worried about a few things. I was worried I would die. I know that sounds really dramatic, but, you know, the history of the feminist movement is, a lot of information about… the history of abortion, and how when it's not accessible or it's not safe, how things can go terribly wrong. And I'm Catholic, or—, I used to be, back in the day. You know. I listened to a lot of myths about how it can physically harm

you." As Gina and Chloe describe, past reproductive experiences link with current ones, influencing and interacting with women's experiences in significant ways.

Emma also speaks not only of her most recent abortion but also compares her recent experience with the challenge she faced in the past—remembering the experiences she faced that led to her previous abortion, 6 years earlier. She says, "My first experience [with abortion] was not a good one. It was very much not necessarily my decision because my boyfriend made me – my boyfriend at the time, and a friend of his. And it was not a good experience… They manipulated me until I made –until I felt like I had no other choice but to make that decision." She demonstrates how this reproductive experience had ramifications years later. She says, "I was very upset and traumatized about it for years."

As these women's stories demonstrate, their dissatisfaction with how their previous social and reproductive health care interactions unfolded, left many unsettling and visceral reactions during their current experiences with abortion. Perhaps it is not surprising, then, that Gina's story made connections between the many distrustful encounters with the medical system that she had to endure as a pregnant teen, and her expectation and fears during the early stages of her abortion experience. In a similar, yet differing way, Chloe describes experiencing loss of trust in the medical system that she felt ought to have protected her from pregnancy. Chloe's experience is also an expression of lost agency of control of her own body, and a dismissal of Chloe's persistent and prolonged wish to have a tubal ligation. And, Emma's story illuminates an experience of coercion and the ways in which a past negative reproductive experience can be traumatizing, and how these feelings can persist. Yet, at the same time, Emma's story also speaks to the ways in which a repeated reproductive event (abortion), centered around a different

set of circumstances (a boyfriend who was supportive as opposed to coercive), led to her remarkably different emotional outcome years later.

New perspectives on motherhood: Growth. Participants' understanding of the meaning and definition of motherhood changed in conjunction with their abortion and other reproductive life experiences. For many women, the abortion experiences were also described as a growth experience. The ways in which women spoke about abortion also conveyed a non-dominant discourse of motherhood, revealing the many contradictions, uncertainties, and diverse feelings and experiences of motherhood.

April described how her understanding of motherhood changed through her experience of abortion. In her narrative, she reflects on experiencing having a hard choice to make when pregnant for a third time and already a mother two children. April recognized, in a way that she had not prior, that "doing motherhood", for her, involved many choices, including abortion. April's narrative expanded the notion of motherhood to include her abortion. April had a strong attachment to her pregnancy, and she described in her narrative both the motherhood feelings she had toward both her living children, and the "little spirit that [she] didn't manifest." April reported feeling connected in a relationship with the "little spirit" and described honouring this relationship through two outdoor birthing blanket ceremonies—one shortly after having the abortion, and another on the date the child would have been born, had she carried her pregnancy to term. April said, "I feel like it's a forever relationship now." April also conveyed the loss she experienced and the mix of emotions she felt some time after her abortion, and stated, "Birth is so powerful. So… that felt like such a huge loss for me too, to not be able to birth, and to have that again…Such a mix of beauty and loss. Love and loss. Grief and love and … all of that." In

this way, April describes her intimate connection to motherhood, and how her emotions to motherhood intermingled, evolved, and grew, even though she did not birth a third child.

Gina, who had given up her son for adoption when she was a teenager, reflected that she didn't always see herself as a mother, but that now, she "honours more the experiences of motherhood" that she has had. She said, "I count my son, whereas, back in the day, people would say, 'Do you have kids?' and I'd be like, 'no'. Now I'd say 'Yes, I do. I have one son who is no longer with me.'" Gina reflects that she had no sense of shame about her abortion, that it is all a part of her "lived experience around motherhood." Gina's narrative brings to attention what constitutes motherhood and demonstrates that women's relationship to motherhood can change over time, but at the same time also shows how women's thinking about their own motherhood may be influenced by predominant and often narrow ways of thinking about motherhood and what constitutes a mother (Downe, 2004; O'Reilly, 2004a).

Emma, the youngest participant in the study with one child, explained how her abortion experience was in many ways made easier because of the connection she felt with motherhood and its implications. Emma noted, "I think I am a better mother because I had an abortion, because it helps me focus on my daughter. It made me feel better about having it, because I knew I was putting her needs first. And I knew if anyone said 'Oh you're a terrible mother! How could you have an abortion when you already have a baby?' Well, that's just it! I already have one! I already have one that needs my attention." Although I was unable to tell whether Emma actually experienced any criticism that she was not a good mother because she had an abortion, Emma's narrative takes a position of resistance against such suggestions.

Although Chloe and Benita, did not describe themselves as mothers, motherhood considerations emerged through their narratives. These women conveyed respect for

motherhood and wanting to govern the arc of their own motherhood experiences. For Benita, she said, "To me, being a mom is like the biggest job in the world. It's not something that should be like 'Oh no, we did something and now we have [a baby], oh, we'll just deal with it after!' You should be prepared and plan for it. And we have to allocate financial resources to that." For Chloe, even though she did not want to be a parent herself, and could have never imagined being pregnant, she identifies as feminist, and recognizes the importance of motherhood in the context of reproductive health. Chloe says, "Recognizing that if I want to do pro-choice work that I have to be as staunchly advocating for motherhood…. for safe motherhood, for respectful motherhood, for empowered mothering, as I do for abortion." Both Chloe and Benita talked in their narratives about the value of mothering in society. They expressed the importance of having economic resources available to more mothers. For instance, Chloe spoke about the importance that women be provided with clean drinking water for their children, and safe spaces to live, free from abuse and toxins, for example.

Women also spoke of motherhood in ways that defied standard motherhood discourses of the "good mother". Donna conveys this matter-of-factly, calling being a mother "the best and the worst thing in the world. It's wonderful, and it's awful. And I love it, and I hate it. [A]nd I'm totally comfortable living with those contradictions because I feel it's totally normal." Donna reflects on being very happy with her "motherhood journey" and in the same paragraph talks about understanding the different experiences that women may desire of motherhood. She says, "It's like the best and worst adventure in the entire world. And, I completely get why someone would want to stay child free… and, I also get why some women ache for babies. I did want to be a mom. I wanted a boy and a girl. But, life changes." Gina also reflects on her growth as a mother, learning that motherhood entails uncertainty, although she did not know this

as a teenager. Speaking about being pregnant as a teenager, she says, "I hadn't had the life experience to know that every mother feels [uncertain]. But at that time, I worried about blowing it, basically. And, umm, the world we live in really affirmed that... People would say, 'Well, what are you going to do in February, take the baby on the bus? And, it's snowing?' … Now I look back and think, people take babies on the bus all the time! Like, people bring them to class! They don't care!"

Many of women's discourses reveal non-dominant ways of thinking and speaking about motherhood. Non-dominant abortion discourses often get lost among more visceral and reactive stories, such as abortion regret and grief. Chloe, a participant in the study, said that women's complex and varied stories of abortion are often lost in research that "is anything other than that really dominant 'I regret my abortion and you will too!' narrative." Notably, in this series of interviews, women's stories defy the dominant discourse of abortion regret, centralizing instead, women's circumstances (both past and present) in their decisions for abortion. Motherhood and women's control centre prominently. In the following sections, I look at additional themes that detail women's experiences, including the second major theme focused on supports (and how supports are experienced by women) and a final major theme on factors affecting access to optimal care.

Theme 2: The Pivotal Nature of Support

Meaningful support was echoed in some way, variously categorized as subthemes of: emotional support, informational support, instrumental support, and appraisal support in each women's accounts of their abortions. For women, deciphering who they could turn to for support, including who would provide support in "knowing what to expect" was considered important in many women's stories about abortion access.

Emotional support. Partners, friends and sometimes other women experiencing abortion at the same time and place provided emotional support. In the case of emotional support, many women entrusted supportive others with their abortion stories. Moreover, women in the study often looked to others going through the same experience and tried to build support with others experiencing abortion simultaneously, for example, friends, and those who were experiencing abortions simultaneous (other women at the clinics). When accessing abortion, women also spoke about not only who supported them, but the caution that they took to avoid discussing their abortion decisions with certain persons in their circles and networks whom they deemed unsupportive or perceived as unsupportive, of their decisions to have an abortion.

For several women in the study, they named their partner as a primary emotional support person, acting as confidants with whom they could share their feelings about the unexpected pregnancy. Emma shared her boyfriend's supportive words when she first shared with him that she was pregnant. She says, "He sat on the couch with me as I cried, and he just held me. He said, "It's gonna be okay, it's gonna be okay. We'll make it okay… I'll support you no matter what." According to Emma, the support she received from her boyfriend was substantial, and was demonstrated in her boyfriend's commitment, including his actions leading up to (talking and arranging the time off to drive her to the clinic two hours away), during (staying with Emma in the clinic), and after the abortion (getting Emma into bed, telling her not to worry about the blood stains on his car seat). Emma's experience was unlike the experience Emma had with her previous boyfriend, several years earlier, when she had a previous abortion. Thinking of her first abortion several years prior, and the lack of support in that case, Emma recalls, "The first [abortion], I didn't have a support system; I didn't really have anyone I could talk to about it.

Because, my boyfriend… didn't want to talk about it. He didn't want to have to deal with it… So, we just didn't talk about it."

Friends were another source of significant emotional support to women in their experiences. April recounts the tremendous emotional support she received from her circle of friends. April recalls, "My friends are very dear to my heart, so it was shared with them. [It] was part of this whole process. And they just, they all said that they would completely support me, in whatever I decided, and totally understood why." However, while friends were generally seen as supportive, sometimes well-intentioned comments were also described as challenging to hear. Complicating the emotional support she felt from her friend, April reflects on the co-existing discomfort she felt hearing her one friend's premature over-excitement about her pregnancy, woven within her unconditional support. April said, "She was super excited for me. And she kept saying, like, 'Yeah, you're going to have a totally healthy baby, and this is going to be wonderful… but, April, I want you to know that I will also be one hundred percent there if you decide this isn't going to work for you either.' It was just like feeling her excitement and her 'but I'll be there', that was hard." April's story of support and excitement bring to attention the ways in which friends may be in difficult positions to know how to best attend to women's emotional needs especially when women's decisions about pregnancy have not yet been made.

Aside from their partners, women did not purposefully involve or disclose their abortions to their families, including women's own mothers. For some women, the option of discussing their situation with their mothers was simply not an option. Benita reflects that she was not able to tell her family any details about her abortion. She says, "My parents are very traditional. And so, that's not how conversations happen." Fiona avoided conflict by avoiding those whom she saw as likely to be emotionally unsupportive. Fiona revealed that she had some discomfort about

the idea of telling her mom that she had an abortion, and accordingly, had not disclosed her abortion to her mom, at the time of the interview. She says, "The thing that I found hardest was umm, not knowing who I could openly talk with. We didn't grow up in a religious household or anything like that. So, that aspect doesn't come into play… but I just had this feeling that if I told my mother, that she would… not disown me, but, there would have been some conflict." Chloe recalls significant conflict that arose in her family when disclosing her plans for abortion. Chloe mentions that although she has a large cohort of pro-choice friends, she was still unable to completely escape the messages of those who did not support her decision, including "a conflict with family when they found out." In contrast, Gina, whose mother passed away when she was young, expresses sorrow about not having had her mother's support. Gina describes both of her pregnancies (the first resulting in adoption, and this pregnancy resulting in abortion), "I think to myself, my being pregnant, well, [my mother is] the person I would want to talk to, both times! And I don't have that person!"

Somewhat unexpectedly, most participants also received support, and reached out for support, and offered support to women who were going through abortion experiences concurrently. Participants identified feeling support from simply being in the clinic with other women, a sort of shared bonding experience, with women whom they had never met. Chloe reflects, "I found comfort in that this is a very commonly performed procedure" and Emma said "…all these other women who were there, and they knew. You're making a decision and it's not an easy decision. … It felt very supportive to have so many women back there, because they understand what you're going through. With women we're making the same decision. You can't really judge someone for having an abortion when you're there having one too."

Some participants spoke about their attempts to make connections with women who were having abortions at the same time as they were. Chloe did this indirectly, in her dual role as an abortion counsellor. Chloe recalls counselling a woman about to have an abortion who had the same last menstrual period date as she did. Chloe remembers going home and taking a pregnancy test and discovering she was also pregnant. Chloe recalls how she felt about this circumstance by saying, "So, some very weird, like, fortuitous, bizarre, circumst[ance]… in a way [a] comforting moment. … to be able to connect." April and Fiona also felt compelled to make connections with other women at the clinic, and they attempted to do so directly. They spoke about wanting to connect with other women, but this being tricky and, at times uncomfortable and which led them to question appropriate boundaries. April talks about the conflict she felt reaching out to one woman she saw at the clinic. April reflected, "At one point, and I felt guilty about this later, because I so just wanted to reach out to somebody. There was a woman that was older, that I tried to speak to. And you know, I said, "Oh you seem like you're around my age. And she said, 'Yeah,' I said, 'Yeah, I have kids, it's hard for me to be here.' And she said, 'I do too, but you know, we're doing what we need to do', so, it was a comfort to me, but it felt jarring, because I reached out, and that whole piece—is it ethical to be reaching out—and, just the culture of silence that was in this piece." Fiona also recalls trying to reach out to a woman who was by herself and who was headed the same way and given the same map to the hospital-based clinic. Fiona recalled that she noticed this woman was by herself, "And, I said to her, 'Hey, looks like we're going to the same place!' At that point, she just gave me this awful look, and I just thought… I felt bad. Later on, she was not in recovery with the rest of us. So, I don't know if she backed out; and I just… I hope that my interaction with her didn't … wasn't what changed her mind, I guess… in the end."

According to most women, emotional support from positive interactions with health professionals, including nurses, counsellors, physicians, ultrasound technicians and admin were considered an important part of their abortion experience. Benita found clinic staff to be very helpful in her experience. “I found everyone at the [abortion clinic] to be very helpful… I found they were trying very hard.” And, likewise, Emma who had two abortions, reported, “All the nurses were as incredible as they were the first time around. And so, I just remember feeling very supported when I went.” She continued, “I had a very supportive ultrasound tech. She made this little joke, you know “It seems like everyone who comes in today [knows] exactly when their last period was, it’s awesome!” Similarly, Donna recognized her physician as playing a pivotal role in her ability to access abortion care. Donna says, “She was amazing!” Amazing! Amazing!” However, some interactions were less supportive. The ultrasound experience stood out for Fiona who remembered, “The ultrasound technician was … she was not a pleasant woman. … I think she came across cold and curt, I guess. That could just be a personality thing.”

Instrumental support. Instrumental support refers to tangible types of support, for example: transportation, child-care, and costs (House, 1981). All women were partnered at the time of their abortions and commented that their partners had been supportive people in their decision-making and, in several cases, coordinating the logistics of having an abortion. In the interviews, the participants described their partners were engaged as supports as: drivers to the appointments (April, Benita, Emma, Gina, Fiona), involved in researching clinics (April), and checking-in on women post-abortion (Benita, Emma). Donna also considered her ex-partner to be instrumentally supportive, because he took care of her children during her many abortion-related appointments.

Instrumental support was also received from health care professionals. Donna credited her personal connection to a friend of hers, a nurse, as pivotal in linking and navigating her to personalized appropriate abortion care. Through her connection to a public health nurse, Donna was connected to a local physician who provided medical abortions in her city. This physician not only provided medical care, information, and a prescription for Mifegymiso, but also assisted Donna to access all the prerequisite blood tests and ultrasounds required. Remembering her experience with the physician, she says, "She was amazing! … She told me everything I had to do." Donna's narrative suggests that care providers outside of traditional abortion clinic settings can function as key resources in linking women to care providers providing abortion. This is perhaps particularly true, in Donna's case, living in Northern Ontario, and living outside of where abortion clinics are located. Having nurses, and other care providers who are well-connected with the few abortion providers in a small city can be invaluable resource, as it was for Donna. Donna's story highlights a key role for nurses in facilitating access to the instrumental support needed as part of abortion care provision.

Informational support. To obtain information about the abortion experience, many women in the study turned to friends whom they knew had had previous abortions. Often, as in the case of Fiona and Gina, women sought out female friends who had experienced abortion themselves and found that the advice received from these women to be especially valuable in providing details about "what to expect." Gina recalls, "I talked to a friend who had miscarriage. She has kids, she also had an abortion… and she really did a public service for me by telling me a bit about what the abortion was like." Likewise, Fiona recalls, "I had a friend, actually, she had an abortion about a year before I got pregnant. … So, I knew she had this done, and she was my first phone call." Later on during the interview, Fiona elaborates about her friend, "You

know, she's one of those people who know exactly – if you need something, here are the channels to go down! … She was one of the first people I told, because I knew that she would be accepting no matter what I decided. And, that … she would be willing to deal with my like, crazy, emotions as I sorted this out. … And, I'm sure I would have had other friends willing to listen, but because she'd just gone through that same experience, I found that, like, an extra level of comfort too." Fiona's story highlights the importance of having community/friend support from someone with a lived experience of abortion.

In contrast, however, both Emma and Benita made specific mention that they did not speak with any friends about their abortion prior to having it. Emma disclosed having few friends that she felt she could trust with her story which was, as she described it, "a bit of a scandal," because she had just left her ex, and got together with her new partner and was now unexpectedly pregnant. For Benita, even though she was close with her sister and family, she understood that abortion was not something that she could speak openly about with her family. She did not mention any friends with whom she talked in her narrative and relied heavily on the informational support she received from the abortion clinic nurse.

It was found in this study that although it was common for partners to provide instrumental support to women, partners rarely provided informational support. April's husband, however, provided what I suggest is a combination of emotional and informational support by sharing his personal feelings with April about the pregnancy and his views about having another child. April recounts her husband sharing with her this message: "If I'm going to actually check in with my heart and say how I feel, it's that I think that this will destroy our lives… We're older, I'm tired, I don't wanna be… the father to a ten-year old when I'm in my mid-fifties…. For our children… we're not going to be able to do any of the things as a family that we do

currently…You know, and everything's gonna get tighter." April did not describe, nor did April seem to suggest her husband was controlling in expressing these thoughts, but, rather, April expressed finding the information to be helpful in her abortion decision-making process.

Participants expressed wanting to get information about what to expect from an abortion experience from clinic staff and allied workers. Gina, for example, reflected about the helpfulness of having a counsellor to prepare her for the abortion, and to provide her with insight about what she could expect. And, Benita expressed having an overall positive experience with the health care providers she encountered and having the opportunity to ask questions in advance of her medical abortion, even mentioning taking notes during the pre-abortion counselling session, which she described as helpful.

However, not all informational interactions with clinicians were considered entirely supportive. April recalls one conversation that she had with a doctor as she was trying to decide whether abortion would be a good choice for her. She describes the physician's demeanor by saying, "It was a strange mix of like, a certain pushiness, but this other space of… kind of a matter of fact, like, yeah, it's obvious that this isn't going to work for you. Which, at some level, was… supportive, but in a weird way." Benita reflects about her frustration when the nurse on-call phone was not answered as she began experiencing awful pain during her abortion. Benita remembered, "She wasn't answering the phone… first I called, I left her a message. Then I texted her. Then she didn't respond." Benita recalled being uncertain how long to expect the pain to last and worrying about how many pain killers she had left, since she was only given four in total. Although Benita had received substantial informational support in the pre-abortion appointment, Benita faced significant barriers to informational support during her abortion itself.

April and Fiona, both mothers over 35 and with 2 children each, suggested the value of being given information, but also felt that some information provided seemed excessive and unnecessary. For example, Fiona found the questions asked by the ultrasound technician to be unnecessary, such as "Would you like to know the sex of the baby? And, would you like to see the ultrasound?" April also found her ultrasound experience distressing, in part due to some oversharing of information. She was told that on her ultrasound, "the boundaries weren't clear" and through this, she became hopeful that her pregnancy may not be viable, which would have, in her description, made her decision to have an abortion much easier. However, when she asked the ultrasound technician to explain more, April was told by the ultrasound technician that she could not share anything further. April recalls the ultrasound technician telling her, "The boundaries aren't clear" to which April said, "Please let me know what that means, because if this isn't a viable pregnancy…that's going to give me so much comfort. And then she [the ultrasound technician] said, 'I can't tell you that, I'm sorry.'" Professional informational that was sensitive and timely was important to women throughout their abortion experience. When it was missing, this gap was noticed by women and left impressions on their experience.

Appraisal support. Appraisal support can be defined as information that is useful for self-evaluation and esteem building (House, 1981). It is not emotional support per se, but the notion of "you've got this!" to encourage women along in taking steps that will lead them to their preferential outcomes. Support of this type was sought by a couple of women in the study. In Chloe's narrative, she sought out her colleagues whom she saw as confidantes with high levels of expertise to assist. At the time Chloe became pregnant, she was involved in an abortion counsellor training course. In the interview, Chloe described how she asked for her classmates

to counsel her, “in the same way that we do clients, so I feel more mentally prepared.” Chloe remembered this exercise as “extremely helpful” as she prepared for her abortion.

Gina recalls how sensitive she became when unexpectedly pregnant and described how helpful it was to receive the information she needed to have the courage she felt necessary to go forward with the abortion. She says, “After I talked to this gal on the phone, the intake person who walked me through and explained the options, I was like… I can do this! You know? It made me feel like I had agency! It made me think, I can make a decision. I can! This sucks, but there are things I can do, and I’m going to do that.” Gina also described feelings of relief and normalcy by seeing ‘women who looked like her’ at the clinic. She said, “… at the abortion clinic, you see all kinds of women! Like there were a couple of women who looked like me. What happened to me, happened to them! You know, like you thought you couldn’t conceive, or that you thought it wouldn’t be so easy, and then this weird thing happened. A few women in their 40s, and women of all different races!”

To summarize Theme 2, women experienced support in many forms, including: emotional, instrumental, informational, and appraisal support, both by those people in women’s lives and those met as part of their abortion experiences. The opportunity to discuss “what an abortion is like” with someone who has gone through the experience was seen as especially helpful to women. And, while emotional support was considered to be key, participants described the limitations of support and the caution they took in sharing their experiences with others. Next, in the final findings major theme, I look beyond women’s personal stories, and the support they experienced, to look at factors affecting access to optimal care, as reflected in participant stories.

Theme 3: Factors Affecting Access to Optimal Care

Women in the study spoke about a wide variety of abortion access experiences and implications. Women's stories were not only individual stories, but women also spoke throughout the interviews about the collective abortion experiences, for example, stories of shame and silence. Women also provided stories that spoke to greater social barriers to access, for example, the limitations on women's reproductive freedom. At times, these stories seemed to reinforce dominant discourses, while at other times, counter-discourses were shared.

Navigation and timelines. Navigation and timelines were deemed very important by women in accessing abortion. For many women, the Internet was the first place women sought to source practical information about abortion clinic locations and service hours. For others, the Internet was a place to obtain information about what they could expect during an abortion. April asked her husband to do some research, and he went to the Internet, finding several clinics, some of which were offering the abortion pill, while others were not. Based on information sourced from webpages, April went to the one clinic in her area that offered medical abortions, however, upon learning that the clinic required several pre and post-medical abortion visits, she opted for a surgical abortion, which was offered to her as a single appointment. April recalled that the information about the number of visits was not clearly explained on the abortion clinic website, which she found added to the confusion and uncertainty about the experience.

Gina who had several poor experiences when she was pregnant as a teenager, nearly two decades earlier, spoke about the widely different experience she had right from the beginning with her abortion. Gina said that the first thing she did this time was look up abortion clinics on the Internet. She said, "So, I looked up the websites, and the first thing you learn about abortion is that you and 100,000 other women have googled the exact same thing. It's great that there's

tons of information online now… online websites that offer [abortion] services or provide referral services, so you can learn about it, and get the lay of the land, because, … I went through my who life without having to know. I knew about reproductive rights, but I didn't know much about accessing it, or about options. I didn't even know there was medical abortions until I started looking into all this." Gina was directed to abortion supports using a local online tool that assists with selecting appropriate abortion services, based on a few screening questions (e.g. "How many weeks along are you? What city do you reside in?) Gina spoke very highly of the tool, and recalls: "It's an interactive tool, and it tells you places in your vicinity that would offer the services you are looking for. So, that's how I got connected with [clinic], and that's where I went."

Included in the subtheme of access, many women spoke of the importance of being able to access a timely abortion. Once women made the decision to have an abortion, most reported wanting to have it done as soon as possible. For Benita, she summarized this feeling in her opening remarks, by saying: "I started looking up places that are available, and for me the most important thing was to find somewhere that can do it relatively quickly, available on a weekend, because I didn't want to take time off work. Some [clinics] have, you know, wait times—this much!" Fiona described having to wait two weeks for her abortion, and questions whether this was necessary. She says, "Waiting the extra two weeks was… it's not a b-a-d amount of time, it's just that I was already experiencing morning sickness, and like … I just felt so gross!"

Gina was also very clear in confirming how important easy and timely access was to her. She mentions feeling physically ill early on and being consumed with the horrible experiences of pregnancy. Gina reflects on what it was like to wait a certain amount of time before an abortion. She says, "Once I knew [about the pregnancy], when I called them, I had to wait another two

weeks in order to meet the requirement date, because you have to be a certain amount along in order to go through with the procedure. She continues, "The idea of access was really important to me. If I went and got any amount of resistance, I would just literally freak the fuck out." Worrying if her pregnancy would be visible on the ultrasound, Gina said, "If I showed up and they said, Gina, you've got to come back in a week, I'd just be like, 'Can you put me out for a week?'… I just couldn't do it."

It is not surprising that women expressed wanting timely access to abortion services. For Chloe, who also volunteered in an abortion clinic as a counsellor, remembers the early abortion access she was given, and recounts how meaningful it was to her. She says, "I was only about 5 weeks, so typically they try to avoid doing surgicals that early, but because they knew that I would follow-up if needed, they were willing to book it, and I was very lucky again. I think I have a very specific experience because I knew how the system worked." Like Chloe, for many of the women, timely access was pivotal to their satisfaction with their abortion experience. Timely access offered a valuable mechanism to assist with coping of an unexpected pregnancy, especially considering the sometimes traumatic and uncomfortable ways that women described their pregnancy experiences (both the physical and psychological).

Environments and unexpected costs. The abortion care system operates in a variety of settings. For instance, hospitals, abortion clinics, and, more recently, some walk-in clinics/family physicians are also providing and managing abortions. Most women in the study had abortions in the traditional abortion stand alone clinic or hospital setting (n=5) or interacted with an abortion clinic to get medication for an at-home abortion (n=1). One participant, Donna, who had a medical abortion, accessed her abortion through a community physician and did not attend an abortion clinic nor a hospital to access her abortion. Provincial health care insurance

covered most costs for all seven women in the study. However, in Ontario, two women paid block fees in the range of $50-70, a type of extra billing, given they went to clinics not fully funded by Ontario Health Insurance Plan (OHIP), that is, not deemed Independent Health Facilities by the Ontario Provincial Government.

As described by participants, the clinical sites women attended varied in the degree to which they adopted a women-centered philosophy. Participants who visited abortion clinics and the hospital setting described the physical environments that made up women's experiences, including the physical space and amenities at abortion clinics. Both Fiona and April spoke of attending clinics that felt like they were cold and uninviting. Fiona recalls arriving at her appointment and recounted: "We walk down the hall, we get to this place. There a buzzer to buzz in and let them know. For security. We're in this tiny, little, weird, waiting room that would have been the set for some psychiatric horror movie or something. There's this old fan, like spinning around in the corner, and all these old chairs that are obviously, that used to be the nice chairs for the hospital." April echoes this comment, saying, "It was an awful place. Like, it was just kind of dark, and it felt very much like a … factory almost. It really kind of felt like this factory service conveyor belt kind of a thing… and it was just kind of a cold environment. Kind of hard chairs, and yeah. There wasn't any warmth to it." These detailed specifications about the clinic and hospital abortion settings suggest that women are seeking warm and comfortable environments as part of their abortion experiences, but that this is currently not given priority at the settings many attended.

In addition to wanting a warm and inviting place, women in the study also expressed wanting somewhere they could bring their partners, and where there would be room for their partners. But, Benita describes, "It was busy, there was nowhere to sit. So, they basically had,

they asked the men to not sit down, so that the women could sit. So, like, we couldn't even talk to each other. So, I sat there, and he was standing at the door." In April's case, she describes being given Ativan (lorazepam), and then sitting in a waiting room for a long while with two other women. (Her partner was not allowed into the room with her.) April describes, "And, I just started feeling very isolated, and they wouldn't let [my husband] come in. He wasn't allowed to come into that area at all." Women looked for their partners' support, but their partners were unable to provide as much support as women would have liked, based on structures and limitations set by abortion clinics and spaces.[3]

Costs were also something that women found jarring, when they came up as part of the abortion experience. Because all women in the study were residents of their respective provinces, women were covered under their provincial plans. However, in Ontario, although OHIP will cover the costs of abortion, several facilities in Ontario, namely newer facilities have not been licensed as Independent Health Facilities, do not receive funding beyond what they recuperate in OHIP billing for abortion procedures (Choice in Health Clinic, 2019; Ministry of Health and Long-Term Care, 2014). Thus, OHIP does not reimburse the entire costs of clinic operations in abortion clinics not deemed Independent Health Facilities. Two women, April and Benita, from Ontario, described the peculiarities they felt about having to pay clinic administrative fees as part of their abortion. For these women, they described not expecting to have to pay, and not being given a rationale for having to pay for a portion of their abortion. For April, she recalls how this "felt gross—like, really, wrong to pay for it. Like, I don't know how to explain it, but it just felt gross!" April talked about paying for the abortion made it seem like a service she wanted, when, in reality, it was something that she needed. Benita also felt that it

[3] April mentioned later learning of another nearby abortion clinic that did offer the option for men to attend with women during the abortion appointment but knew that this policy was rare.

was odd to pay and said, “I know if you don’t have OHIP. Obviously, I’m not expecting the government to subsidize this. But, I didn’t have any expectation that there would be any additional costs.” The costs of the abortion also raised questions about the authenticity of the abortion clinic operation, from participants’ perspectives. Benita recalls being asked for cash at the clinic she went to—credit and debit were not accepted—which she found increasingly peculiar, especially when no explanation was given for the cost.

Culture of silence and stigma. Participants in the study described the degrees of secrecy they took in navigating their abortion experiences. In some cases, women admitted to breaking the expectation of secrecy. Chloe was very open and described her steadfast belief in the importance of “truth telling” as a way to eliminate the silences affecting women’s reproductive justice. In her own personal account, Chloe’s determination to share the truth about her work absence (for abortion) was paramount, even though her courage was met with resistance from her coworkers. Chloe’s commitment to sharing her abortion story represents a deeper commitment of hers, which is to normalize the right to abortion.

Fiona described the pressure she felt to adhere to secrecy at work, after becoming pregnant, and before her abortion. Fiona described working in a female-dominant profession and the strong pressures she felt to be secretive and deceptive, especially around one colleague who had already predicted that she was pregnant. She says, “There were two coworkers at work who figured things out, because I had started getting sick. Tara might be part witch – she can smell when you’re pregnant! And, she was super excited. But, she’s super Catholic. So, like, I knew that I was going to have to… call in sick the day of, and lie to these people… And lie to Tara later on, that like, all of a sudden, I’m not pregnant anymore. And that made me feel icky about the situation … I don’t feel like I should have had to lie to people.” Navigating work

uncertainties about abortion—on the one hand wanting to be open about it, but on the other hand, not feeling that abortion is socially accepted, seems to be a complicating factor in women's stories, and a complicating part of their abortion access experiences, certainly in the cases of Chloe and Fiona. Chloe's pushback for being open speaks to the social dialogues deemed acceptable for women. The social acceptability of abortion discourse in women's lives plays out strongly in participants' stories.

Participants spoke about stigma as connected to their experience of abortion. Participants spoke both about the individual stigma they faced, and also spoke of the stigma in what they recognized to be the larger, collectively stigmatized experience of abortion. Women sometimes also compared the extent of the stigma they experienced, with the extent of stigma they believed to have existed in the past, including stories and cultural and religious mythology of abortion.

Benita reflects on having access to abortion in Canada. She says, "I think people still have… there's some stigma associated with [abortion], but I don't think it's nearly as it was before." Similarly, Donna talks about abortion stigma being widespread in the city where she lives, which she describes as being run by "old boys" occupied with overall anti-choice sentiment. Donna says, "I think there's still a lot of anti-choice sentiment in the city. … So, big stigma, and it's good that I can do it all secretly, for the most part. … So yeah, I think there's still barriers. But, not as much as there used to be. If you get in… if you have the right connections, you can get in really easily."

Social stigma may also contribute to perpetuating definitions and expectations of motherhood. Gina recalled the kind of stigma that faces mothers who are not "perfect mothers", as defined by society. She said that for many years she never talked about her son, because she said, "People would get weirded out, they wouldn't know what to say about the fact that you

gave your child away. You know?" Gina continues, "To me, motherhood is connected to some like, systemic inequity that makes you feel inadequate or that it's impossible. Or, even being too traumatized to continue was informed by that first experience." Gina also spoke about her father, who, upon learning of her new relationship, said: "I always thought it was unfortunate you broke up with [your ex] when you did, because you never had children. And, I'm not saying you should but I'm just saying, if it happens, that would be okay!" The question about what constitutes motherhood—and how Gina's father sees or does not see Gina as a mother—is triggered in this statement.

Bearing witness to in-person protests and virtual protests against abortion was one of the ways in which participants described experiencing abortion stigma. Donna noted the pervasiveness of anti-abortion sentiment in the city in which she resides. She says, "Every so often I'll drive by a Walmart and I'll see there's a pro-life, or rather, an anti-choice display of a little… [eugh]. Like, random people just walking, and there's been a few… protestors at the entrance to the hospital. There's [also] been a few ridiculous comments online, like, 'Oh, I heard there were 500 abortions in [the city] last year. So, like, just think! We're all worried about the declining [city population]. Just think! That's 500 future voters!' … I'm just like, 'That's not how it works!! Idiot!!'" Emma also talked about seeing Facebook posts that stigmatized abortion as "taking the easy way out." She challenges this remark, saying, "It's like, it's not a decision anyone makes on a whim! It's not like, oh my god, I want to have an abortion! Like no! That's not how it goes!" Fiona sums up the stigma by describing what it is like to hear the politics of abortion by saying, "It's a hard enough decision and process on its own, let alone having so—, like, strangers hav[ing] their input on what you're doing with your own body."

Similar to stigma, many women also linked the silences they experienced with what they saw as the larger culture of silence of abortion. They connected the overall culture of abortion silence to rarely talked-about subjects, such as abortion over 40, and the culture of silence of abortion at work, and in family. April and Gina were both women over 40 at the time of their abortion. As part of the culture of silence, Gina describes the lack of information and discussion about women, fertility, pregnancy, and abortion after 40. She says that when she resumed being sexually active, after a period of abstinence, she reread the fertility awareness book that she had followed perfectly in the past. She says, "I did review the chapter that reviews specifically the chapter for when you're over 40, and how things might be a little bit different. And, of course, there's a lot of myths about you being less fertile. I think that's complete bullshit, now that I think about it. Because so many things that could be different, will change. Everything!" She continues, "…and, when I got up Sunday morning, my temperature was high, which shows that you ovulated. So, it literally happened on day 5 or 6 of my cycle. Which … if you had told me that could happen, I wouldn't have believed it, but that's what happened!" April shares a similar story, saying that, "My cycle is incredibly regular, and I'm [over 40]. And so, my husband and I had unprotected sex, completely outside of my regular, I mean, it was, I had had my period just a few days before. So, I wasn't that worried." April and Gina's stories suggest that there is much silencing about older women's abortion needs, and, more broadly, fertility changes as women age in their reproductive years. Strangely, fertility over forty is not a topic I have read much about in the abortion literature, despite knowing that women in this age category do have abortions.

Due to the silence and isolation accompanying abortion, April sought out a support group for older women who have had abortion. Despite April's attempts to find an abortion support

group, and despite living in the GTA, she was unable to find one. In the interview, April suggested that she felt women like her need spaces to express their experiences; spaces where women's abortion experiences are not politicized, but rather personalized and comforting. After not being able to find the support she needed, April discusses her work developing an abortion support group. She says, "So that's when it became important to me, to feel like part of this journey might be about creating that option for women. … I feel like it's an important place that I feel needs to grow within women's access to support, and to break the stigma and the silence that is so pervasive, and so, like, such a wide, scary, quiet, to feel like you have nobody to talk to without the fear of judgement, or being told that you're bad, or wrong. And, how common it is, for women to have the experience. You know, I found myself sitting at [my] team meeting at work, and just thinking… has anybody here had an abortion? Like, who can I share this with? …Just this veil of fear, and shame, and silence."

Chloe made particular mention that she hopes my research will be shared broadly, and reach many people, such as to continue to break the silences of abortion. She also was weary of "different types of abortion research", and mentioned, "My fear with research like this, or research in general, is anything other than that really dominant 'I regret my abortion and you will too' is how quickly it gets lost."

Women's situatedness, privilege, and equity. All participants spoke, to varying degrees, about "being lucky", both in their ability to access abortion, to have the support they did, or the resources they did to obtain abortion. Participants contrasted their experiences with those of the women they saw around them and the experiences of hardship that women knew existed for women globally as they attempted to access abortion.

Emma, a mom of a young daughter, reflected on her reproductive experiences. She says, "I'm very grateful that I have the choice to be a mom. I am very grateful that I, you know, when I was pregnant with my daughter, I had the choice to keep her. I had the choice to have an abortion. I had the choice for adoption. I had that choice! I can never imagine being forced into motherhood. I couldn't. I am very grateful that I got to choose to raise my daughter; I got to choose to carry her to term. And I'm very grateful I got to choose to have an abortion, especially the second time around."

Among the women participants, there seems to be a sincere recognition that their experience is not a universal experience, for many women, in many places and spaces different from theirs. Many of the participants were keen to share their sense of privilege for being able to have their abortion, and it being possible for them to do so. They reflected knowing that access to an abortion might not be so easy for many other women. Chloe speaks about living"[w]here the services are offered in the province, and so, I was lucky in that regard. I also, like I said, I think I have a very sort of specific experience because I knew how the system worked, and I think that for so many that's the scariest part, is all of the not knowing." "I didn't have the fear that many people have of the unknown. I was very lucky in that I had a good concept of what was coming and knew how to access the services that were best for me. Like, knew where to go; which would be the best fit for me."

Even in Donna's case, a single mother of three, who describes living in a "rat infested" home, she talks about being privileged in her ability to access an abortion. When I asked her about what abortion access was like, she began her story by situating herself as a woman in the world. She says, "I know how lucky I am. And I know how incredibly privileged I am. I mean, my family's always been really poor. And my ex never made any money. I mean, we'd do food

banks and things like that. But in the grand scheme of things, in the world, I know I'm among the riches, the top 3% if you count the whole world…. After breaking up with my ex-husband, I just made my friends like my family. And, just held them close, and will do anything for each other. And, just the fact that I had these connections. I've got connections, like everywhere! … And, so my access to the abortion was super easy. And it pains me that not everyone can say that. It's very sad, and I'm so lucky." Donna expresses sadness thinking of other women who may not have the access experiences she had. Donna says, "Sometime I have even like survivors' guilt. Not survivor… but… Oh man! I had it so easy, and all those other poor women, don't!" Donna summarizes the interview, by sharing, "I guess my overarching theme is that I feel super blessed, super lucky to live in Canada, and to be surrounded by the people I'm surrounded by, who give me these connections." Donna's dialogue speaks to the fact that abortion is not considered a human right globally. Even when abortion may be considered a human right, Donna's narrative expresses how access is still difficult in many cases. These women's juxtaposition of their own experiences against the experiences of others showed their awareness of abortion injustices and conveyed their frustration of the injustices in women's differing access to abortion.

Fiona also described the sense of privilege she felt being able to have an abortion. She explains this through the "funk" she fell into after having the abortion, and that lasted for a couple of months, despite all the support she received. She reflects that she was able to overcome this "funk", adding, "That's with support. So, honestly, if somebody didn't have, if they were going through this alone, it would be very frightening, and … And, even… at the end of the day, I'm supported. But, ah, yeah, I really, hope in my heart that people have support as well." In thinking about others, Fiona thinks also to the future—about her daughters, and her daughters'

friends, and hopes that they will have support to have an abortion, if they ever needed. About young women, she says, "I mean, I was thirty-five or something at the time when this happened, and it was frightening for me. I couldn't imagine having to go through something like that at sixteen, when you're so … just so much more impressionable, you know? … I sincerely do hope that people are able to make the choices for themselves, right? I was just a very fortunate girl, to have all the support that I've had. I am comfortable to come and tell a complete stranger, you know?"

Despite her previous traumatic pregnancy as a teenager, Gina described her story from a lens of privilege. Gina talked about some of the information she read online, about the access hoops some young women had to jump through to access abortions in the United States, including gaining parental support, or going before a judge, in order to obtain an abortion, for example, teens living in Florida. Reflecting on her findings Gina says, "The amount of hoops that a young women in my situation,—that I had been in, back in the day as a teenager—that you'd have to engage your parents support, just to access that [an abortion] … I just thought, I'm so thankful for the situation that I'm an adult and that I understand my rights, and that I have rights. I thought, this is exactly my kind of fear! The things that I did not experience, but that I worried about, coming into it. Because I didn't know anything about abortion before I started on this journey. That was for sure." Of her situation, Gina says, "I would say this situation was the best circumstance. I was lucky that I had a supportive partner, and I didn't have to ask my parents or anything like that."

Women also paused, and, in telling their own stories of privilege, compared their situation with their curiosity about the women they saw at the clinic, often sympathizing with these other women's situations. Gina recalls seeing one woman at the clinic, whom she

described as a young mother after noticing this woman was talking about her kids to a staff member. Gina reflected, "Here she was having an abortion. And, she needed to take the bus home. So, they hung onto her for longer, because she was leaving on her own. And, I thought, MAN! Being a woman is so hard for some people." Gina described her feelings of privilege comparing her situation to the young mother's and said, "I live in an urban place, I have a car, someone to drive me. Even if I hated it. I mean, I guess if you lived somewhere rural or northern, you'd probably run into more barriers."

Benita also recounted her shock overhearing the receptionist speaking with another client about the fees for abortion. Benita recalls, "She was obviously going through the fees, I think… fifty dollars [administrative fee]. But, then she gave the girl the option, that if you don't have OHIP, whatever-*hundred* dollars! And I thought, oh god! This is really expensive … if you don't have OHIP." She reflected again at the end of the interview: "I don't know what happened to the lady who didn't have the OHIP coverage."

One thing that stood out in the interviews was the way in which participants connected their experiences to the broader social and political meanings of abortion. In some cases, women made connections to the limited reproductive options women have, and the shame that women face regardless of whether they choose to have an abortion or whether they have a child. Women noted the variety of reproductive experiences people have, and how there is little room for variation in women's reproductive discourses.

In a few cases, women spoke about abortion as being part of a set of limited reproductive choices for women. Chloe describes this best in her accounts, reflecting on women living in poverty and specifically, Indigenous women. For these women, Chloe notes that: "You have a right to parent in oppression, in significant oppression that will have a significant impact on you

and your child. Or, have an abortion. Either way, we're going to shame you. Either way, you won't have access to the resources you need." Reflecting on some of the personal work she was doing with Indigenous women, Chloe explained how for many Indigenous women, reproduction was sometimes a form of resistance, a way of passing along culture in a world that had (and has) systematically tried to erase Indigenous bodies and culture. She says, "If people are still being given one option, that's not really choice, right? If your choices are to parent with the possibilities of having your child removed from your home, or being forced to bring your child up in a home that is not safe, or being endangered in your pregnancy… or, [to have] abortion. Is that choice?" Chloe goes on to describe the limited choices women in these situations often have, taking note of the limitations of the social system to provide for the well-being of children. Chloe says: "It's devastating seeing people who don't want abortions; people who do want to continue their pregnancies, people who do want to be parents, but who have to think critically about what practical reality am I bringing a child into."

True reproductive freedom, as Chloe points out, has not yet been attained for many people. Chloe links her abortion experience to being denied a tubal ligation. Chloe attests that it is only because she was denied true reproductive freedom—a tubal ligation—that she was faced with the need for an abortion. Chloe describes fighting for a tubal ligation from the time she was 14 years old and recalls the specific pushback she received from male physicians who insisted, despite Chloe's convictions, that she would change her mind.

Under the theme of Factors Affecting Access to Optimal Care, women encountered several organizational barriers—such as policies restricting access to their partners support; and cold and uninviting environments. At the macro level, women encountered barriers such as the culture of silence and stigma surrounding abortion, and recognized many socially-produced

limitations to reproductive freedom. Women knew of their relative global privilege in their ability to access abortion and spoke broadly about abortion barriers facing women.

Chapter 5: Discussion

This study explored the experiences of seven Canadian women who accessed abortion between May 2015 and May 2018. In this chapter, I return to the findings to apply a critical feminist analysis to women's narratives, illuminating the gendered social structures and implications on women's lives. I also explore the limitations of this study and explore what these findings may mean for future nursing practice, research, and education.

I originally posed four research questions:

1. What are Canadian women's stories of abortion?
2. How do women experience access to abortion?
3. What factors influence women's access to abortion?
4. How is motherhood relevant to women's stories of abortion?

These questions led to three major themes that emerged from the narrative data and were presented in the findings section: 1) Storying Women's Experiences; 2) The Pivotal Nature of Support, and 3) Factors Affecting Access to Optimal Care. In this chapter, I explore what these themes may suggest and/or present about gender and the social, political, economic and structural nature of women's abortion experiences. Drawing on a number of concepts, I talk about and situate the thematic findings in the literature, making links, for example, between social support and access; between the emergence of the abortion pill and women's autonomy; and, between the culture of abortion silence and women's reproductive justice. I take these themes and discuss them through a critical feminist lens, looking specifically at concepts related to: 1) Women's voices – Stories of Control, Agency and Support 2) Institutional and Cultural Norms – and Resistance, 3) Motherhood Journeys, and, 4) Reproductive Justice.

Women's Voices – Stories of Control, Agency, and Support

Autonomy, choice, control. It is important to hear from women, and we hear women's voices to understand the complexities of women's lives as they articulate it. These women's stories are already filtered through their own lens—and are an articulation of the space in which myself and the participants came together to share and listen. This section offers insight into the ways in which women's described experiences are gendered and the impacts of this. It was important to hear from women's voices because it is women's voices that are able to counteract women's gendered experiences, which can often include the experience of being silenced. Most of the participants in this research study expressed gratitude for the opportunity to tell their stories. Reissman (2008) suggests that "telling a story makes the moment live beyond the moment" and cites Paul Ricoeur who wrote: "A life is no more than a biological phenomenon as long as it has not been interpreted." In my interpretation, many of the participants expressed sentiments like these—that echoed wanting passionately to expand the reach of their stories—because they knew, both the intimacies of their stories, and the shared commonalities, and most were keen to contribute to diminishing the silences of abortion stories. "Being unable to tell your story is a living death and sometimes a literal one" and "liberation is always in part a storytelling process: breaking stories, breaking silences, making new stories" (Solnit, 2017, p. 19). In telling their stories, and their desire for support groups in which to tell more stories, women in this research make claim to their voice—that is, to reduce the silences surrounding the topic of women who have abortions, and their human right to self-determination and to agency (Solnit, 2017).

Still, the stories heard in this research are largely representative of women of moderate-to-high socio-economic backgrounds and education, and who are mostly white. These

demographics warrant critique and examination, particularly as it applies to hearing women's voices. "Being heard is a kind of wealth", whereas, "silence is the universal condition of the oppressed" (Solnit, 2017, p. 23-24). This research highlights the prominent voices of women who self-identified as willing to tell their stories, and it thereby reflects women who had a certain "kind of wealth", or, certain type of stories, from those with enough social capital to share their stories.

Historically, and still persisting today in countries across the world, many women's abortion stories highlight a lack of access to safe abortions (Ganatra et al., 2017; WHO, 2018). Connections between abortion and maternal health have shown how inadequate access to abortion care puts women at increased risk of mortality (Ganatra et al., 2017; WHO, 2018). Abortion for reasons related to maternal health was the subject of the death of Savita Halappanavar, who died in Ireland after being denied an abortion following an incomplete miscarriage and associated pain (BBC, 2012). Savita's case became a point of focus which later resulted in the legalization of abortion in Ireland in 2018 (RTE, 2018). In contrast, connections have been made between positive maternal health outcomes and countries with less abortion restrictions. Latt, Milner, and Kavanagh (2019) studied the connections between flexible abortion laws in 167 countries and found that countries with less restricted access to abortion had lower rates of maternal mortality.

Although Canadian women are unlikely to face heightened risks of maternal mortality due to the availability of abortion in Canada, little has been written about the existing health conditions facing women when they seek abortion. Omissions in research are notable, because, what is not told about women's lives can reflect the incomplete understandings of women's experiences, considering that knowledge is always partial. Pregnancy literature often focuses on

the joys of pregnancy. But, for a few participants, pregnancy was not an easy experience, which factored greatly into their abortion experience. For most of the participants, pregnancy difficulties and discomforts were described as part of their experience. Women described being acutely aware of their bodies' changing symptoms and physical manifestations. For some women, they expressed being unable to cook, or care for their living children, because their pregnancy-related symptoms caused great discomfort. Still, other participants suffered discomforts with hemorrhoids, painfully enlarged breasts, and with memories of trauma experienced during earlier pregnancies.

However, in having an abortion, many participants felt they regained control of their bodies—and were able to exercise their own decision-making. This is a feeling also described by author Sadie Roberts (2016) of her abortion. She says, "The [abortion] procedure itself was redemptive. Finally, able to regain control over 'her' body which she felt had been hijacked for many weeks" (2016, p. 164). Many of the women in the study expressed how having an abortion was exercising control of their futures and reproductive outcomes. Often, pregnancies are portrayed as things that are longed for, desirable, wanted, and sought after (Layne, 2003). However, in this study, pregnancy was seen as an unwelcome experience for most women. When women became pregnant unexpectedly, many expressed feeling betrayed by their bodies—a feeling also found by Trybulski (2005), in women she studied 15-years post-abortion. Some authors have speculated that self-determination themes central to present-day liberalism play strongly on women, leading women to believe that they ought to be able to control their fertility, even when this may not be possible (Layne, 2003). Thus, when women experience an unplanned pregnancy (notably, a common event occurring in greater than 60% pregnancies) this may disrupt women's sense of self-determination (Layne, 2003). Unexpected, unwanted

pregnancies, and abortions disturb the very nature of the way in which pregnancies are often socially portrayed—as such exclusively happy events, and not as events that may lead to alternative outcomes (Layne, 2003). By having unwanted and unexpected pregnancies, and by controlling reproductive outcomes with abortion, women in the study challenged commonly held beliefs of the meaning of pregnancy.

Abortion decision-making is often complex, although not always portrayed as such. According to women's narratives, the decision to have an abortion was, for some, described as a hard choice, but one that participants said they were willing to make in order to regain reproductive control in their lives. Being thrust into the experience of an unwanted pregnancy necessitated that women consider the multiple future directions that their lives might take. When April described to her children about making her abortion decision, April uses the term "hard choice" in her description, a subtheme in the findings. The term 'hard choice' gives more context than 'choice' alone. It suggests consideration about the complexity of choice-making that participants described and helps to showcase the fact that choices are not made in isolation, but are rather, generally, extremely contextual, and, like, Janiak and Goldberg (2016) suggest, not "elective abortions" but rather "necessary abortions".

Women spoke too of their choices being due to circumstances—their available living space; their incomes; their lifestyle; and readiness, such as being in the same country with their partner. In some cases, participants entertained and imagined what it might be like to have another child, and these stories were told emotionally and longingly. Nonetheless, this emotional desire expressed in women's stories was contemplated alongside their circumstances to make a finite decision (to have or not have a child). Hurley (2016) has written about the coexistence of desire and circumstances in abortion-choices, and is critical about the term choice, implying that

sometimes choice is constructed around a notion of desire (to want or not want a child). However, she finds that more often desire is present, but is superseded by circumstance (Hurley 2016). Hurley writes, "[c]hoice implies that desire trumps circumstance, while I believe the opposite is frequently true" (2016, p. 88). That is, that circumstance is often the primary reason women cite for having an abortion; not that they don't want a child. Like Wiebe et al. (2012) who describe women who often wait for the circumstances of their relationships to be right before bringing in children, so too did the women in this study speak about postponing motherhood—delaying it until their circumstance was right—for instance, until they were living together with their partner in the same country, and in other case, waiting until the relationship had been established a little bit longer.

Although choice is recognized as a longstanding aspect of the women's reproductive rights movements, Gustafson & Porter (2014) argue that focusing on choice often individualizes the concept of choice, such that choices come to be "reduced to discrete decisions about, for instance, whether to use contraception, continue a pregnancy, or have two instead of one child" (p.43). For many women, choice is effectively non-existent, due to how others control them or control policies about them. Thought of this way, choice is more of a social construction than individual choice—and such "choices" differ based on social location, identity, and as a product of time, influenced and interacting with contexts of power and privilege in which we all live (Gustafson & Porter, 2014; Lippman, 2014).

The concept of women's choice can be expanded by looking at socio-economic realities and the determinants of health that intersect with women's circumstances, a concept often termed "the social construction of choice" (Lippman, 2014). When women make considerations about abortion, many times it has to do with socially-determined factors. Earle, Komaromy, Foley, and

Lloyd (2007) suggest the socio-economic contexts for many women's abortion "choices" and wrote that "[p]overty and social exclusion remain one of the most important factors in determining women's reproductive health" (p. 3). Such truths rang out for many of the participants who spoke specifically about their means and/or their experience of living in poverty in their respective stories. For example, the participants' desires to keep their children's home spaces familiar and consistent was a similar finding across many women's narratives. Women wanted to live within their means, but also wanted to protect their children from being uprooted to larger and unstable households and to prevent the added stress which they perceived would come from the addition of another child into their lives (an experience that a few women had been through in their childhoods).

Women's bodily autonomy can be defined as "the right to self-governance over one's own body, without external influence" and is a key component of women's gendered analysis, particularly as it relates to women's abortion access and rights (University of California Santa Barbara, 2019). An important and timely consideration for this project was to explore the experiences of women's access to, desirability for, and overall experiences with medical abortions with Mifegymiso. Two women in this study had experiences with Mifegymiso (2/7). Two additional participants considered Mifegymiso as an option. For all women, it was important to have the opportunity to select their preferred method of abortion. These stories highlight the importance of client-centred abortion and personalize some of the reasons why Health Canada's approval of Mifegymiso was a critical step in advancing reproductive health care and choice for Canadian women. These findings support those of a Swedish study that found women in that country were keen to have choice in the method of abortion, along with the appropriate support and information tailored to their self-care needs (Makenzius, Tydén, Darj, &

Larsson, 2013). Moreover, a Canadian study performed before Mifegymiso's approval suggested interest and desire from Canadian women for more abortion options, including medical abortion in Canada (Vogel et al., 2016), which seems also to be the case among urban women in this study.

Women's self-determination has long been an important aspect of abortion care. Choosing the type of abortion is one such way women are exercising their autonomy and decision-making. Winnikoff and Sheldon (2012) make the argument that medical abortions create an option for women in the developed world who wish to avoid surgical abortions, while, in the developing world, medical abortions provide "a safe and discreet means for early termination of unwanted pregnancy" (p. 164). In both settings Winnikoff and Sheldon (2012) argue that "medical abortion[s] ha[ve] reduced women's dependence on medical systems, providing them with greater autonomy and control over their most important reproductive decisions" (p. 164). Self-management of abortion was the central theme at the Abortion Beyond Bounds Conference at McGill University in October 2018 that recognized and explored, in particular, issues of agency in the context of Mifegymiso. This included a recognition of women's bodily autonomy, and that women have long used creative means to access abortion for themselves, especially in cases where access has historically been restricted, either by policies, or geography, or by an exhausting amount of appointments (Abortion Beyond Bounds conference, personal communication, 2018; Luna, 2011).

In addition to women's self-determination to abortion, formal calls for the reduction of medical personnel in abortion have been championed worldwide. The World Health Organization suggests that "abortion and post-abortion care can be performed in early pregnancy by a range of health workers, including non-physicians" (WHO, 2016). The WHO (2016)

recognizes the need for expanded roles and fit of nurses, midwives, and other trained clinicians, in order to increase access to safe abortion. Already in Australia, "medication abortion is predominantly a nurse run service" (Savage & Gibbons, 2017). In Canada, abortion provision by nurse practitioners has been authorized since 2017 (College of Nurses of Ontario, 2017).

Support. Women's health care needs are not always fully met, heard, and valued, yet, it is essential that we hear from women about what optimal care looks like in their lives—in order to understand and meet women's health needs. This research highlighted the various forms of social support included in women's stories of abortion, and, in this section, I examine what support means in the lives of women, and explore further the nature of support, and who is involved in support, and contrastingly, who is not. Drawing from seminal work in psychology by James House (1981), there are generally considered to be 4 types of social support: Emotional support, instrumental support, informational support, and appraisal support. Emotional support refers to expressions of empathy, love, trust and caring; instrumental support refers to tangible aid and service; informational support refers to advice, suggestions, and information; and appraisal support refers to information given for self-evaluation (House, 1981). In this research, women sought meaningful support in their abortion experiences and drew upon various types of support as ways of overcoming barriers and resisting common discourses silencing abortion. All four types of support were described by participants, with emotional support and informational support featuring prominently across women's narratives.

Despite abortion being silenced in women's own experiences, women found supportive people to be with them during their abortion experiences. Much of the emotional support received was from the participants' partners at the time of their abortions. However, participants not only received support, but also reached out for support, and offered support to women who

were “going through the same thing.” The participants describe this as seeking a shared bonding experience, despite feeling, at times, unsure about doing so, and appropriate ethical boundaries they should follow. Participants seemed to experience a concurrent conflict between wanting to be supportive to other women, yet, feeling guilty for reaching out. As I listened and reflected on women’s stories, I questioned the silencing of women’s health issues, historically thought of as “unspeakables”, and wondered whether other health concerns might be similarly unspoken about, or not. Participants’ narratives of uncertainty and guilt after their attempts to reach out to other women, despite their attempts to disrupt abortion silences, seem to reinforce the culture of silence that surrounds and mystifies and stigmatizes abortion (Stettner, 2016). However, women’s agency also made me consider the nature of informal support networks formed in abortion clinics and how these informal structures may be evidence of women’s self organization, not completely dissimilar from acts of consciousness-raising.

Although men’s experiences were not central to the study’s aims, men’s experiences are also gendered, and looking at men’s experiences and hegemonic behaviours can be informative to women. In most women’s accounts, conversations with partners were wholly supportive, yet assigned, in effect, all decision-making to women. That is, men were not considered to be involved in the decision-making processes. However, in one case, one participant’s partner’s self check-in conveys a strong involvement in childrearing and what it takes to raise a child. Kluger-Bell (1998) suggests that men tend to stand in deference to women in pregnancy loss and abortion and suggests that many men’s voices are lost in these experiences. Kluger-Bell (1998) speaks about a widely held cultural belief that suggests men are only remotely affected by matters related to reproductive issues, and how this gendering of men’s interests and investment in children results in a widely held bystander portrayal of men in reproduction. Earle, Foley,

Komaromy, & Lloyd (2008) describe that disruptions to men's reproductive life courses hold significance for men, and Kluger-Bell (1998) suggests that men's involvement in decision-making about their children is critical to men becoming nurturing parents. Thus, silencing may not only be affecting women, but may also affect the narratives that men feel able to express in the context of dominant gender norms that continue to dictate appropriate gendered behaviour for men and for women.

Examining also the people that women did not include in the provision of social support is also informative and may highlight the ways in which some topics are repressed or silenced in various circles. Despite the fact that women brought up their mothers in conversation, none of the six participants whose mothers were still living chose to disclose their abortion to their mothers. The type of reproductive health information women shared openly with their mothers, and what women concealed, may reflect the persistence of stigma that remains attached to abortion.

Women sought out female friends who had experienced abortion themselves and found that their advice was especially valuable in providing details about "what to expect". Statistically, given between one-in-four to one-in-three Canadian women will have an abortion during her lifetime (Dunn & Cook, 2014; Norman, 2012) it would seem that it should be fairly easy for women to know someone who has had an abortion. However, due to the clandestine and secret nature of abortions, it may be difficult for some women to identify others who have had an abortion experience that they could approach for informational support. This was the case even among these participants, who were highly educated, and who self-described as having many resources. Thus, the support of abortion clinic counsellors and staff may be critical to the provision of necessary information about the abortion experience, given the covert ways in

which abortion experience exists, where support persons in women's own social networks may not be easily identified.

There may also be additional concerns for women's agency, if women are not taught about their sexual and reproductive rights in school, through progressive sexual health curricula. In Ontario, for example, there are concerns among nurses and educators and calls for the reestablishment of a modernized sexual health curriculum (RNAO, 2018). Promisingly, in June 2019, new Canadian Sexual Health Guidelines included abortion as part of comprehensive health education that can enhance reproductive health. Specifically, the Sex Information and Education Council of Canada (2019) takes the position that comprehensive health education involves "[e]quipping individuals to navigate and overcome systemic barriers to accessing contraception and reproductive health care (including abortion and midwifery services)" (p. 14).

Institutional and Cultural Norms—and Resistance

There are links between the micro (individual), meso (institutional) and macro (larger policies and structural) levels. So far, I have discussed mainly micro (individual) considerations, for example, the meanings of women's experiences with pregnancy, and their support structures. The meso level will be the main focus of this section, recognizing that all levels are interconnected and have influence and are ultimately connected to the experiences of women. At the intermediate, or meso level, a number of institutional policies restricted and complicated abortion access. Women seeking abortions encountered a number of policies, or, ways of doing things, that raised questions of what was behind decisions, and why certain clinical operations "were the way they were." This was true of women encountering unexpected ancillary costs for an abortion in Ontario, not being allowed to have their partners present for the abortion procedure, and the seeming lack of attention to the provision of comforting environments for

women. As I understand from recent communications within my professional networks, ancillary costs (or, extra-billing block fees) are meant to cover: 24 hour call-lines, work and school sick notes, and test results over the phone, for example (A. Moore, personal communication, July 1, 2019). Women also made mention of what they felt were unnecessary wait times, and, in some cases, uncomfortable ultrasound practices. Navigating toward an abortion in a technological era ripe with misinformation is also discussed in this section. Not only do organizational (meso-level) policies have effects on women's experience, they also represent the ways in which the organizational-level policies are linked to government policies and illuminate the politics and social gender norms entrenching abortion—and women's health—at the margins of healthcare, thus keeping substantial power and decision-making out of the hands of women, and in the hands of institutions and policy-makers.

Physical spaces can serve to value and enhance experiences, or they can do the opposite, and this is perhaps nowhere more the case than in the spaces women occupy (Stettner & James, 2016). In their feminist geography research, MacDonnell and Andrews (2006) note that among human and health geographers, several have indicated the impossibility of separating health and healthcare from the places where healthcare is delivered. The physical environments of abortions formed a significant memory for women, who often described abortion spaces as cold and uninviting. For precisely this reason, Stettner and James (2016) advise that abortion clinics create a sense of community in their spaces. For example, Dr. James suggests that the clinics serve tea in regular mugs, that clinics use nice, up-to-date colour schemes, have comfortable seating, and provide options for women to journal, or draw during the time that they spend waiting (Stettner & James, 2016). Contrary to the notion that sees abortion as a time of loss, Dr. James's suggests that the experience of an abortion can be a time of great courage and strength

for women, and that the spaces ought to reflect areas where care can be given and received. It seems necessary, therefore, that in order to demonstrate a valuing of women, that the spaces women traverse in accessing health are also valued.

In addition to wanting a warm and inviting place, women in the study also expressed wanting somewhere they could bring their partners, and where there would be room for their partners. Women sought their partners' support but suggested that their partners were unable to provide optimal support due to limitations set by abortion clinics and spaces. Dr. James agrees that partners should be allowed to be present and supportive to women during their procedure (Stettner & James, 2016). Unlike other reproductive events where men can be present during the procedure (labour and childbirth, for example) men were not allowed to be a part of the experience, even if women wanted them to be. Although some clinics do offer the option for the presence of a companion (for example, "allows a support person to be present" is a parameter that can be selected using Shore Centre clinic's online abortion clinic finder https://referral.shorecentre.ca) it was not an option available to women undergoing surgical abortions in this study, at the clinics they attended.

Reasons for restricting access to men during the abortion experience are generally cited as reasons of patient safety and privacy (Nguyen, Hebert, Newton & Gilliam, 2018). With respect to privacy, despite the attempts by clinics to keep women's experiences private—this was not necessarily experienced by the participants in this study. Women reported being in packed clinic waiting rooms, being knee-to-knee with women in secondary rooms, and side-by-side with women in recovery rooms. Exploring more opportunities for "building in" privacy, proactively and retroactively in clinic design and policies seem meaningful to honouring women's requests and limiting the ways in which women's health care concerns are often dismissed. But, while

privacy is important for many women, so too, is the opportunity, in non-coercive situations, to have partners present (Altshuler, Nguyen, Riley, Tinsley, & Tuncalp, 2016). Moreover, the inclusion of willing men in the abortion experience may have merits, and could contribute to the demystification of abortion, enhance the provision of support for men's experiences, and reduce the perpetuation of the myth of men as mere bystanders in reproduction (Earle et al., 2008; Myers & Nevill, 2010; Nguyen et al., 2018; Papworth, 2011).

Women also expressed facing what they considered bizarre policies around costs. As women described the bizarre nature of paying for abortions, the way they described the experience made it seem the way it would feel to pay a fine for an infraction that was not committed. A fine, in this case, for someone doing something deemed "socially wrong" or deviant. Costs for abortion, in effect, monetizes the way in which women are penalized for their sexuality. While some clinics will waive fees, the whole ordeal of being asked about ability to pay for the administrative costs of an abortion, despite the Canada Health Act guaranteeing access to insured medical services, is troubling and filled with gendered marginalization of women's health needs. As described earlier, several facilities in Ontario, namely newer facilities, have not been licensed as Independent Health Facilities and do not receive funding beyond what they recuperate in OHIP billing for abortion procedures (Choice in Health Clinic, 2019; Ministry of Health and Long-Term Care, 2014). Thus, despite the fact that, under the Canada Health Act, all costs associated with abortion should be covered under medicare (National Abortion Federation, 2019), provincial policies in Ontario and New Brunswick do not allow for full reimbursement of clinic operations at abortion clinics outside of hospitals, or, in the case in Ontario, at clinics not deemed "Independent Health Facilities" by the Ontario government (Ministry of Health and Long-Term Care, 2014). Advocacy continues with the hope

that the provincial governments in Ontario and New Brunswick will eliminate all costs associated with abortion. The refusal to fund further clinics, despite the reality that women continue to seek services preferentially in clinic settings, draws attention to policy limitations that affect women's access to abortion. This gap remains an area that may require further advocacy in order to achieve full reproductive health equity.

The bio-medicalization of women's health—and abortion—has been the topic of feminist critique for some time (Paterson et al., 2014; Purdy, 2006). The language of biomedicine has also been critiqued for concealing women's reproductive experiences of loss (Jonas-Simpson & McMahon, 2005). Feminists have long been critical of the statement that an abortion decision is "a decision between a woman and her doctor" for being paternalistic and centering medicine in women's decisions (Purdy, 2006). It has been suggested that biomedicine has often been prioritized over women's reproductive control, and moreover, that this practice is so pervasive, and longstanding, that it can often be hard to recognize (Purdy, 2006). Aldrighi, Wall, Souza & Cancela (2016) found in their literature that most pregnancies in women over 35 are written about from a risks-based perspective, whereas much less was written about the experiences of women who are pregnant and over 35. In this study, women disclosed not being able to find much information directed at the experiences of older women who were pregnant, and specifically, for older women having abortions. This aligns with the overall limited research on older women's reproductive experiences.

Mandatory ultrasound requirements present a contemporary tension between biomedicine and women's health in Canada. The very need for ultrasounds arises from the biomedical need to date gestational age of pregnancies, and rule out ectopic pregnancies (Fraser, 2017). However, ultrasound machines are expensive equipment and without them on site, create

additional, and known barriers for women's access to abortion (Fraser, 2017). In fact, the very need of ultrasound intervention for abortion is being entirely questioned by some feminists, who critique the Western trend of "medicalizing deviance" (Cain, 1991). Thompson, citing Petchesky, is critical of ultrasound and the biomedical impulse to "see inside" (Thompson, 2017, p. 64). In many ways, I see the ultrasound stories of participants in this study as illustrations of the prioritization of ultrasound protocols over women's ways of knowing, their agency, and their rights to self-determination. Notably, in recognition of persisting barriers, and, perhaps the over-medicalization of abortion, Health Canada removed the mandatory requirement for ultrasound prior to medical abortion, in April 2019 (Government of Canada, 2019; Zingel, 2019). The removal of systematic control of women's bodies represents a welcome step away from powerful policies restricting women's agency and bodily authority.

Access to timely services has historically been important for optimal women's reproductive justice, particularly among women who face substantial geographical barriers in accessing abortion in Canada (Sethna & Doull, 2013). Participants sought abortions quickly after they made their decisions, and many expressed wanting to have abortions sooner than the 6-week gestation that was typically recommended by their doctors. Mifegymiso is currently indicated for abortion in Canada under 9 weeks, and with the recent elimination of ultrasound requirements pre-abortion (Zingel, 2019), there may be more opportunity for earlier and timelier access to women, which may better suit women's needs. In my research, women expressed how timely access offered a valuable mechanism to assist with their ability to cope with an unexpected pregnancy, especially considering the traumatic and uncomfortable ways that women described their pregnancy experiences (both the physical and psychological). Providing timely

access to women responds to their needs for effective care, and respects women' knowledge and knowing.

Many women reflected on the larger culture of silence of abortion, linking the silence they heard throughout their own abortion experience with the larger cultural silence around the topic of abortion. They linked the overall culture of silence associated with abortion with rarely talked-about subjects, such as abortion over 40, and the culture of silence of abortion at work, and in family. Silence can permeate women's experiences, contributing to gaps in knowledge, support, and understanding about women's health.

There may be a particular sense of silence for women over 40 in this study. As part of the "culture of silence, participants in this age demographic described the lack of information and discussion about women, fertility, pregnancy, and abortion after 40. These stories suggest that there may be much silencing about older women's abortion needs, and, more broadly, fertility changes as women age in their reproductive years. I reflect, too, as part of my reflexive practice, on not finding literature that speaks specifically to women over 40 and their experiences with abortion. More commonly, however, women's fertility after forty seems to be the target of other biomedical, and often costly, medical interventions, such as fertility drugs, and egg freezing, and attempts that are made at prolonging women's fertile periods—so as to maintain the cultural obsession with mothering (Thurer in Duquaine-Watson, 2004).

Navigating dialogue about abortion—on the one hand wanting to be open about it, but on the other hand, not feeling that abortion is social accepted by those in their social circles, seemed to be a complicating factor in several women's stories, and a frustrating part of their experiences. Women feared pushback (and in one case received pushback) from colleagues, friends, and family for having an abortion. Such feelings and experiences exemplify the social dialogues

deemed acceptable for women. A key Canadian nursing research finding in McIntyre et al. (2001) was that women often had difficulty determining whom they could trust to share their abortion experience with, and feeling, in some cases, silenced from sharing their story, and a tension between their feelings and the realities they were living. Similarly, in this research, I found that women's stories support this sentiment of uncertainty about who to trust and feeling the need to keep some information secret and hidden from certain untrustworthy people, including employers. Anti-abortion discourses that reinforce traditional femininity may be acting as contributory to the silencing of women's stories (Abrams, 2015; Bourgeois, 2014).

However, women also displayed strong resistance and commitment to truth-telling, even enduring risk of and real push-back from doing so. Like the narrative researcher Riessman (1993) found in her research, some women, are keen to provide voice to an experience they see as largely silenced. Within this context, the suggestion about the need for safe and supportive groups—and specific support groups for older women—to dialogue about abortion arose. Some women spoke too, about being active on social media sites—following Canadian sexual health and rights organizations on social media, for example. This is perhaps not surprising, considering that women have long facilitated the bringing together of women's lived experiences, with this sometimes resulting in consciousness-raising, and social change (Poole, Bopp & Greaves, 2014).

Motherhood Journeys

Motherhood is stratified along a continuum of good-and-bad mothering wherein the biological bearing and raising of children is most promoted (Downe, 2004). In the case of this research, participants who had abortions but did not have biological children living with them, were reluctant to identify as mothers in relation to their abortion. Building on work by Gayle

Letherby (2002), Downe (2004) suggests that there is a 'hierarchical dichotomy' established between women who are mothers and become so in "typical" ways, versus those who become mothers in "unusual ways". She highlights the social dismissing of "other" mothers, in the same ways that women in this study, at times, dismissed their own mothering experiences. This conceptualization of motherhood by women who have abortions seems consistent with the socialized nature of motherhood, where women who identify as "other mothers" (for example, fostering, adoption, grand-mothering, older-sister-as-mother, and step-mothering) receive far less attention (Downe, 2004; MacDonnell 2006). Therefore, in many ways the knowledge of "other" mothers, remains subjugated.

In this research context, pronatalism refers to the social and cultural obsession with maternity and the promotion of reproduction by direct or indirect influences (O'Reilly, 2004a). Social narratives also imply and reinforce motherhood as desirable for all women. This was true among women participants as they interacted with friends and colleagues. In her work Duquaine-Watson (2004) suggests that a number of scholars have suggested an American "cultural obsession" with mothering. Speier (2004) further suggests that there exists a "feminine imperative" for mothering (p. 141). Beginning in the 1970s, the advent of birth control pills created more control over mothering timeframes, yet, the notion that women would become a mother and wife endured, while all other options were harshly questioned (Speier, 2004).

Yet, in many ways in this research, women defy the notion of pronatalism and instead speak of their need to be something other than mother. Accordingly, women set limits on their mothering capacities. The women in this study showcased a wide variety of reasons for controlling motherhood, such as: not desiring motherhood; financial stability; work and school

obligations; and relationships circumstances. In defying pronatalism, women reject the prescribed discourses they are assigned, and instead exercise their own agency.

Still, participants in this study did live in a largely pronatalist world, and some of their experiences highlight intersections and conflicts with pronatalist ideals. In a few cases, participants' colleagues, friends, and family made prematurely excited comments over pregnancy, and, in another case, made eye rolls at the prospect of having an abortion. These experiences seem to suggest the ongoing operation of pronatalist ideals in Canadian culture where larger social narratives, culture, and media continue to imply and reinforce motherhood as desirable for all women, whereas to do otherwise is often questioned (Duquaine-Watson, 2004). Participants describe being part of a larger social narrative that reinforces motherhood and the difficulties that arise from implied motherhood. The notion of a "second chance at motherhood" came up in the research and raises a question of whose second chance is being granted. It is arguable, for instance, insofar as social norms around the institution of motherhood persist, that second chances at pregnancy might not resonate for women at an individual level, and statements like these may be more reflective of social pronatalist desires for perfect motherhood, rather than women's views of motherhood and their ongoing motherhood journeys.

Women spoke about abortion coexisting in and as a part of their motherhood experience, not as an experience separate from motherhood. Although mothers were not targeted exclusively, 5/7 participants identified as mothers. This alone, defies the often-stereotypical representation of women who have abortions as being exclusively young and promiscuous (Wershler, 2016). For these five women, their motherhood journeys informed and played into their abortion experiences. This seems to speak to women's considerations of their whole selves, and it places abortion not as a singular event, but rather within the larger experience of

motherhood. Moreover, for the participants who were not mothers, the prospect of motherhood, or repeated motherhood, factored prominently in their stories. It is nearly impossible to separate out, especially among the 5 participants who identified as mothers, motherhood as separate from their overall stories of identity. The way women saw themselves demonstrates a more complete representation of women-in-their-lives as opposed to a reductionist view often taken of women.

In storying their abortions, some participants made connections between their abortion and their role of motherhood, claiming that because they felt so strongly that they want to be good mothers to their living children, they opted for abortion. This is a similar sentiment to what several authors have contested, and that Charlotte Taft (2012) has summarized in saying: "Women who have abortion do so because they value life and because they take very seriously the myriad of responsibility that come not just with birth, but with nurturing a human being." (Jones et al., 2008; Williams & Shames, 2004). April, a key informant, provided a narrative that reflects the writing of Erin Mullan: "The most important thing I have learned in my career [as an abortion counsellor], is almost all of us make the decision to end a pregnancy because we care and value children; we want to be good mothers (2016, p. 248).

Motherhood is not only the state of being a mother but is also the social institution of motherhood—the ideological and political frameworks that promote mothering (Coulter, 2010). Both the institution of motherhood and the personal mothering were considered in women's abortion stories, even among women who did not identify as mothers at the time of the interview. Women's narratives conveyed respect for mothering and wanting to preserve mothering as an equally sacred and honourable choice to abortion, yet they were also suggestive of the emphasis of motherhood in society. They expressed the importance of mothering, and the need to extend the opportunity for mothers to be able to do good mothering. For instance, for all women to have

access to the resources they needed to mother (for example, clean water, safe housing). However, women knew that social privilege influenced who was seen as deserving and that this was not self-determined, but rather a decision made by those who had "social authority" to determine who can be a mother at any time.

Women defied the social messages suggesting that real women cannot be mothers and real mothers are not those who have abortions, and suggest, instead, that that all women can have abortions and be on motherhood journeys. As Andrea O'Reilly (2004a) writes, motherhood is often represented in a very different way from how it is actual experienced, calling this the "mask of motherhood" to which women are expected to adhere (p. 12). In telling their abortion stories, women remove their masks, and the realities of their hard choices, inextricably linked with their stories of motherhood, are revealed.

Andrea O'Reilly (2004a) argues that sacrificial motherhood is a common motherhood discourse, and includes, among other key requirements, that "the mother must always put her children's needs before her own", and that "mothering must be provided 24/7" (p. 14). Combined with other tenets of sacrificial motherhood (see: O'Reilly, 2004a), O'Reilly (2004a) demonstrates how sacrificial motherhood is an impossibility, determined by others, that mothers themselves internalize. Furthermore, it is an expectation that mothers will fall short of the requirements of sacrificial mothering, and nearly an expectation that the discourses of sacrificial motherhood are likely to leave many women, at various times, feeling anxious or guilty about their mothering. Similarly, in describing their abortion stories, participants talked about falling short on their expectation of motherhood when they referred to prospective situations not being able to "be there" for their children should they proceed with their pregnancies, such as during a difficult pregnancy, or having to divide their attention between more kids.

Women in this study described how they had a number of uncomfortable early pregnancy symptoms, such as tender breasts, nausea, chronic illness, hemorrhoids, and exhaustion. In a couple of cases, these symptoms were so severe and emotionally provoking that they feared any additional wait times they might face in getting an abortion, an experience also described by Angie Deveau (2017) of her experience with abortion. Along with their symptoms, many women felt they had to also keep these symptoms secret, since their pending abortions were not something they felt were open for discussion. Interestingly, comparisons exist, because early pregnancy is also a time when many women, regardless of their plans for pregnancy, feel the need to be secretive about their discomforts—for reasons related to uncertainty in decision-making and in the viability of their early pregnancies (Kjelsvik et al., 2018; Modh, Lundgren & Bergbom, 2011). In a recent study from Norway, Kjelsvik et al. (2018) found that women in their first trimester, who were yet unsure about whether to have an abortion, reported similar symptoms of fatigue, nausea, sore and tender breasts, and dizziness, and that these symptoms presented a physical and also a social challenge for women who were trying to keep their pregnancies secret. A participant in the study by Kjelsvik (2018) describes this experience as "being thrown on a roller coaster." Yet, despite the commonality of early pregnancy symptoms, I was unable to find much literature that described women's experiences and symptoms in early pregnancy. From a critical feminist lens, this might suggest that pronatalism and the desire to be a stoic and perfect mother plays strongly as a social message directed toward women, limiting the amount of emotional and instrumental support women might be able to receive in early pregnancy.

Women's willingness to take up talking with their mothers and their own children about reproductive health is varied. In this research, only one participant created an opportunity talk

about her decision to have an abortion with her school-aged children. Gustafson and Porter (2014) suggest that choices (and discussions about choices) are made in within families with specific histories and legacies. Gustafson and Porter (2014) argue that in some families, reproductive "body talk" may be underdeveloped, and that it is only as children come to share an experience with their mothers, that their mothers are 'jolted out' of their silence and disclose information about having gone through a similar experience. Gustafson and Porter (2014) also note that family discourses about reproduction also are influenced by social institutions such as the church and medical institutions. For women who speak up about reproductive health within their families, however, there seems an opportunity to unhinge generational silences that can persist around clandestine topics, such as abortion.

The reproductive experiences of reproduction and motherhood were threaded throughout these women's stories, which spanned many years and was not limited to the "abortion event" as such. Similarly, Porter and Gustafson (2012) note that women in their intergenerational research did not see their reproductive roles as limited to their childbearing years. Instead, women expressed being deeply committed to what Porter and Gustafson (2012) term their "reproductive lives in relational moments", and what Bezanson and Luxton (2006) call "social reproduction", or "the process invoked in maintaining and reproducing people… [which involves] the provision of clothing, shelter, basic safety, and healthcare, along with the development and transmission of knowledge, social values, and cultural practices, and the construction of individual and collective identities" (p. 21 in Gustafson & Porter, 2014). In a similar way, women who were not mothers experienced and talked about mothering and their journeys navigating motherhood, regardless of their official status as mothers. More simply, a motherhood journey existed for every woman.

Reproductive Justice

Reproductive justice is "reproductive health integrated into social justice" and is a term that originated in 1994 at a Black women's caucus meeting in the United States (Luna, 2011, p. 227). Historically, abortion was considered central to the reproductive rights movement, however, this movement ostracized many women who were not white, heterosexual, and middle-class, as it ignored many of minority women's reproductive needs, including, for example, forced sterilization, coercive abortions, and being denied the chance to have children (Luna, 2011). As Luna (2011) writes, "reproductive justice extends beyond reproductive rights and 'choice' because it emphasizes how diverse social identities influence access to rights in an unjust society, including reproductive rights" (p. 230). Reproductive justice is not limited to reproductive rights, and "support for motherhood is a major part of reproductive justice action" (Luna, 2011, p. 238). Concepts of reproductive justice emerged in my research as women described various ways that they were marginalized, for example, as low-income and young mothers, and as racialized and queer women.

However, it can also be argued that this research largely reinforces the reproductive health concerns of dominant (white, middle-class, heterosexual, able-bodied, English-speaking) social groups and may overlook the reproductive health concerns of marginalized groups. For example, the waiting periods that were considered bothersome to women in this study due to the delay they caused in abortion accessibility, was a historical protective mechanism, advocated by women of colour to provide, in addition to informed consent, another layer of protection against forced reproductive coercion, such as abortion and sterilization (Luna, 2011). Not merely historical, these concerns remain today. For example, in 2015, a number of Indigenous women came forward to share their contemporary experiences of unwanted, coercive and uninformed

sterilization in Saskatoon, resulting in a city report on the topic of Indigenous women's sterilization in 2017 (Boyer & Bartlett, 2017)

Reproductive justice is useful in the way it expands how abortion choice is conceptualized. Although choice is language common to many abortion rights advocates, it is limited in that is focuses on making formal choice available to women and excludes the contexts in which choices are made (Saurette & Gordon, 2015). In a few cases, women spoke about abortion as part of a limited set of reproductive choices for women, noting that women's right to parent are often limited to either parent in an oppressive states (poor conditions; especially for certain women) or not to parent at all. Participants made critiques of the limitations of opportunities for women to be supported as parents, and specific mention was made for Indigenous women. Too often women are shamed for wanting to parent in situations that are largely out of their own personal control—such as living in poverty. The phrase "Don't choose to bring a child into this world if you can't feed it", for example, is a common message repeated throughout social media. This is an example of how relying on choice as a frame of reference can obscure the structural analysis necessary to understand the context of social choices, particularly in Canadian culture that tends to emphasize and favour individual choice in neoliberal politics and economic practices (Saurette & Gordon, 2015).

In this research, women brought their experiences with abortion together with stories of motherhood and motherhood journeys. Participants, regardless of whether they were mothers or not, show agency in motherhood and abortion, reinforcing the call made by Shaw (2013) for unison between birth activism and abortion activism. More broadly, thinking about reproductive freedom necessitates a question about the extent of the role of the state in advancing true reproductive freedom—that is, allowing those who want to be parents—to parent—and thinking

critically about how the state might extend greater reproductive freedom to more people. For example, Saurette and Gordon (2015) write about how the federal government has held up the notion of parents' choice in determining childcare options but has tended to omit a consideration of structural—and, reproductively just—aspects of childcare, like, for instance, the affordability and availability of parents "chosen" childcare. Similarly, Kaposy (2009) and Medoff (2016) emphasize the need to look at social and political implications tied to abortion access or non-access, as opposed to the medical or individual need for abortion alone.

Reproductive justice was also integrated in this research in the ways in which participants spoke about privilege, whereby participants juxtaposed their own experiences against the experiences of others, demonstrating their awareness of both abortion injustices and their relative privilege. Participants recognized that their experience was not a universally available experience, and women recognized that access differed widely for women in places and spaces different from theirs. In this way, participants articulated their experiences in such a way that provided insight not only into their own experiences, but also the patriarchal structures operating to regulate women's sexuality and gender, and how patriarchal structures can differentially impact women's opportunity for self-determination (MacDonnell, 2006).

The experiences of women of colour is a limitation of this study, given only one participant identified this way, despite this being a sampling consideration. Understanding the experiences of women of colour is important because they are known to face different kinds of barriers and stigma when seeking abortions (Dennis et al., 2015; Pietsch, 2004). As a group, women of colour are known to face significantly more difficulties in navigating abortion (Dennis, et al., 2015). Stigma has also been shown to be experienced differently between women of colour and white women (Pietsch, 2004). Pietsch (2004) writes that while white

women are sometimes temporarily stigmatized for having abortions, their situation is often considered changeable and rectifiable—brought on by mental ills, for instance. In contrast, Pietsch (2004) notes that women of colour are far more commonly stigmatized according to biological determinism suggesting women of colour are permanently sexually deviant, resulting in their need for abortion, a state from which they are thought to never recover. Drawing from Pietsch (2004), differential stigma may provide insight into the number of people with whom women of colour share their abortion experience with; and the number of people with whom they feel they can trust with their narrative and, in turn, the amount of support they may receive as they access abortion.

The reproductive justice field is concerned with the ways in which racialized women's abortion experiences may differ from non-racialized women's experiences. There is some indication from British data (CEMACH, 2007) that show that reproductive losses are unequally distributed, with those from minority (non-white) groups experiencing more reproductive losses than whites (Earle et al., 2007). Future collection and examination of women's demographic data, along with women's reasons for abortion and whether these link to social-economic conditions, could help to better understand the nature and extent of women's reproductive "choice" among low-income and other marginalized women.

Some women in this study mentioned having an awareness, sometimes directly, of the ways in which some religious beliefs about reproduction are imposed on women, including the lack of support for abortion in some religions. The lack of support to make personal reproductive choices, including abortion, has been previously described in some Canadian religious and cultural communities (Gustafson & Porter, 2014; Wiebe et al., 2011). In 2012, global attention was raised to the consequences of religious-based abortion laws after the death

of Savita Halappanavar in Ireland, a Catholic country. According to a report from her husband, upon Halappanavar's request for an abortion, hospital staff told Halappanavar—who was Hindu, not Catholic—"I'm sorry, unfortunately it's a Catholic country and it's the law that they can't abort when the foetus is live" (BBC, 2012). The lack of support for abortion in religious communities has historically been framed around religious teachings emphasizing the function of reproduction within the institution of the family (Gustafson & Porter, 2014; Wiebe et al., 2011). That is, in some religious teachings, beliefs about women's primary functions as reproducers are emphasized and upheld (Di Lapi, 1989; Gustafson & Porter, 2014). For some women, religious teachings not only prohibit abortion, but frame and affect the everyday ways in which women feel towards their bodies, sometimes inducing feelings of bodily shame, particularly related to women's sexuality and desire (Boston Women's Health Book Collective, 2011).

This research is limited in its understanding of persons with diverse genders and sexualities. Despite asking about identity with the LGBTQ2S+ community as part of the demographic questionnaire portion of this research, and two participants identifying as such, little further is known about participants' specific sexual orientations or genders, nor emerged through the participants' narratives. Nonetheless, barriers to reproduction for persons who identify as LGBTQ2S+ have been identified (Lowik, 2017; MacDonnell, 2006; Walks, 2014). Still, and regardless of gender identity and sexual orientation, participants experienced the persistence of patriarchal heterosexist gender norms and the perpetuation of ideas of the institution of motherhood, including among health professionals (MacDonnell, 2006; O'Reilly, 2004a; Walks, 2014). As Di Lapi (1989) suggested, "women's role as mother" is often viewed as compulsory, while diverse roles, sexualities, and conceptualization of motherhood are too often marginalized.

Participants also raised important considerations as they reflected on their younger selves, and as they hypothesized what it would have been like to be young and unexpectedly pregnant. Their narratives raise important concerns about the sexual health curriculum, and what information young women will have available to them, should they find themselves unexpectedly pregnant. Currently, for example, the term "abortion" is not found in the Ontario Sexual Health Curriculum (neither in the 1998 version, nor the currently retracted 2015 version). In fact, Action Canada (2019b) notes that as of May 2019, "the reality is that no curriculum in Canada meets human rights standards, the Public Health Agency of Canada's Canadian Sexuality Education Guidelines, or the UNESCO technical guidelines on comprehensive sexuality education." Many abortion resources are available online, but, are increasingly becoming less distinguishable from pro-life-based resources, such as pregnancy crisis centres (Mitchell, 2018; Saurette & Gordon, 2015). Youth need safe spaces where they can learn about abortion as part of full reproductive health spectrum. The cancellation of the Ontario Sexual Health Curriculum dismisses youth's needs and their right to complete reproductive knowledges.

Inequities among women accessing abortion were highlighted by the unequal costs of access, especially when participants considered women who do not have provincial health insurance, for example, women who are new immigrants to Canada, or women on the wait list for Interim Federal Health coverage, or visitors. Dennis et al. (2015) look at the specific experiences of low-income women who accessed abortion in Massachusetts between 2009-2012 and found that among women who had to pay out-of-pocket for abortions, thirty-three percent of women reported difficulty finding the money to do so, and resorted to borrowing money for the abortion from friends, putting the entire cost on a credit card, skipping monthly bills or rent, and pulling out of limited savings. Consistent with the reports from a key informant in my study,

Dennis et al. (2015) notes that immigrant women are surprised to learn that abortion in the US and Canada is generally by appointment, and not offered on a same-day service as immigrant women were sometimes accustomed to. The practices of booking abortion appointments in advance likely privilege access for women who are born in Canada over immigrant women, and especially so, immigrant women who may not speak English and for whom booking appointments via telephone may present additional barriers. However, medical abortion has allowed many non-traditional sites such as urgent care centres and fertility clinics, to start offering abortion care (Abortion Rights Coalition of Canada, 2019) and thus, as access options increase and with attention to the costs of care, opportunities for better reproductive health may be forthcoming.

Geographical barriers are of concern to abortion reproductive rights and justice. Although all women in this study lived in urban settings, the size of their cities varied significantly. Still, among the urban-dwelling participants, one required a 2-hour drive to the nearest clinic; and another relied on her city's only Mifegymiso-prescribing physician's pro-bono home visiting and personal transportation to get all the required prerequisite/post requisite testing complete. Although not as pronounced as other studies that have described the many geographical access limitations facing women living in rural settings (Cano & Foster, 2016; Foster et al, 2017; Sethna & Doull, 2013; Vogel, 2015), this research illustrates disparate access on a smaller scale between well-resourced women living in the GTA, where there is appreciable options for abortion services, with those living in other settings, where options were less plentiful, and reliance on others for instrumental support, such as providing rides to the abortion and related appointments was essential.

A gender lens is helpful, too, in understanding complexities of women's contemporary experiences accessing abortion. Women's experiences were not just about oppression, but the abortion experience also constituted growth experiences. Women's voices show evidence of being silenced, but also counteracting dominant discourses of silence and stigma. The institutional policies and cultural norms also influence women's experience, but they are also being questioned and examined by women themselves—their necessity, and the barriers they present to more equitable abortion access. Motherhood ideals too, are being questioned—and although pronatalist discourse remained commonplace in the contemporary context, I also witnessed discourses of resistance from women in their motherhood journeys, regardless of whether they were mothers. Reproductive justice challenges the individual notion of women's choices and highlights the ways in which these decisions are structured and embedded in systems of gendered social norms and dynamics of power and control. From this research, it is my understanding that diverse women are unequal recipients of reproductive health care, based on social injustices that continue in Canada.

Limitations

The limitations of the study include the small sample size (seven women). While this provides a rich understanding of seven diverse women, it does not capture the diversity of all Canadian women. Most of the participants were white, all were able-bodied, none identified having a disability, and all spoke English as a first language and had achieved high levels of education. Two women identified as LGBTQ2S+, although how women identified within this diverse group was not further explored in the study. The effect of this mostly white, able-bodied, and English-speaking group of women is that this research presents particular types of experiences of Canadian women. Notably, it leaves out the experiences of many diverse women.

There were also geographic limitations in this study. All participants lived in cities, although the actual sizes of cities were diverse. The effect of studying women who live in cities excludes the rural experiences of women having abortions which, is a group of women who may have particular types of insight into their experiences with Mifegymiso access, given it has long been argued that women living in rural settings have particular urgencies for the approval and dissemination of Mifegymiso.

Recruitment challenges occurred at two clinics where my poster was initially posted whereby the first participants were recruited from a poster seeking “mothers” and the second participants were recruited from a poster seeking “women” (Appendix A). The effect of this is that my study may have excluded women than might have been included had the study originally targeted women. Moreover, trans-men were not included in the recruitment sample, and, the labelling of my posters with “mother” (original version) and “woman” (amended version) may have excluded their participation.

Originally, recruitment occurred through networks that I had through the GTA. Later, I expanded my network to those outside of my personal network. As a result, a possible effect is that my recruitment in the second portion may have been more widely available and drawn the attention of more women who were active or involved with abortion, or pro-choice agencies.

Further studies could incorporate large-scale mixed-method studies on women's experiences to understand the diverse contemporary abortion experiences of women in Canada. Moreover, future in-depth qualitative studies with select populations, for example, non-English speaking, racialized, trans-men, women living in rural locations, and women living with disabilities are populations of interest for study in understanding the diversity of abortion experiences in the contemporary Canadian context.

Implications for Nursing

This study provides an in-depth examination of individual diverse women's experiences with abortion in Canada during the years in which Mifegymiso was first approved and available in Canada. This research will likely be relevant to all nurses because nurses work with women throughout all phases of their reproductive lives. This research has implications for nursing practice, advocacy and research across all setting given that motherhood journeys are relevant to all women, and not confined to a certain type of woman. Stories of abortion are relevant to mothers, non-mothers, and therefore nurses, across settings, and, across women's lifespans.

In nursing practice, nurses do, and can continue to play an essential role in women's reproductive journeys, and in helping women navigate toward abortion care. Nurses studying the abortion experiences of women have asserted that abortion is a relevant area of nursing (McIntyre et al., 2001; Tanner, 2006; Trybulski, 2006b). Moreover, RN prescribing is being discussed as an option for near-future nursing practice (RNAO, 2018) and is an area of specialized practice that may be relevant for nurse prescribing in certain contexts.

At first glance, advocacy might be seen at an individual level. But, from a reproductive justice lens, advocacy may be seen more broadly. Advocacy in feminist nursing is anything that improves the everyday lives and conditions of women's lives and their social determinants of health. Advocacy is an area where nurses are well-known for creating and improving care. There are potential opportunities for nursing advocacy to ensure safe and free access to abortion, for example, by advocating for complete provincial reimbursement for independent abortion clinics across Ontario. There are also potential opportunities for enhancing a more comprehensive reproductive health curriculum in schools. For example, while RNAO (2018) has been a strong advocate in Ontario for the inclusion of a progressive sexual education

curriculum, there is opportunity for this curriculum to be more encompassing and take a reproductive justice lens to health. Given the connections found in this research between women's lives and their motherhood journeys, nursing advocacy might also centre more strongly around interconnected issues such as universal daycare coverage, women's working conditions and environmental policies.

There is also an opportunity for nurses to conduct more research in abortion, centered on women's narratives. What I notice is that there are many nurses involved in women's abortion access stories, and yet, nursing literature does not reflect a wide diversity of women's stories. Research on abortion in nursing challenges silences in nursing that can often permeate the discipline, and influence which disciplines knowledges are heard. Furthermore, nursing might use reproductive justice to consider the meanings of reproductive health more broadly, and the equity implications that might be possible with such an approach. Nursing research could equally benefit from taking up meanings of reproduction across various motherhood journeys, including diverse women across various socio-economic status, orientations and identities, abilities, language, and cultures. Likewise, research focused with a historical lens and a critique of power structures embedded in women's lives has the potential to illuminate areas of necessary change in health and the social conditions and structures affecting the health and lives of women.

Conclusion

Gender and the lens of reproductive health offer valuable tools for nurses to use in practice, advocacy and research. This research brings together the experiences of women's abortion, gender, and access experiences of seven women in Canada between 2015 and 2018. Their stories highlight the motherhood journeys that embed the abortion experience, and while their stories draw attention to persistent barriers to access and to reproductive justice in the contemporary context, they also demonstrate moments of resistance to pronatalist discourses, and provide deep personal understanding of abortion, and the importance of this right to health.

References

Abortion. (n.d.) In *Oxford English Dictionary*. Retrieved from https://www.lexico.com/en/definition/abortion

Abortion Rights Coalition of Canada. (2019). *Statistics – Abortion in Canada*. Retrieved from http://www.arcc-cdac.ca/backrounders/statistics-abortion-in-canada.pdf

Abrams, P. (2015). The bad mother: Stigmas, abortion and surrogacy. *Journal of Law, Medicine, & Ethics, Summer*, 179-191.

Action Canada for Sexual Health and Rights. (2019a). Find sexual health services near you. Retrieved from https://www.actioncanadashr.org/resources/services

Action Canada for Sexual Health and Rights. (2019b). Statement on Ontario's sex-ed curriculum. Retrieved from https://www.actioncanadashr.org/news/2019-03-19-statement-ontarios-sex-ed-curriculum

Adichie, C. N. (2009). *The danger of a single story* [TED Talk]. TED Global. Retrieved from https://www.ted.com/talks/chimamanda_adichie_the_danger_of_a_single_story

Aldrighi, J. D., Wall, M.L., Souza, S. R. R. K, & Cancela, F. Z. V. The experiences of pregnant women at an advanced maternal age: an integrative review. *Rev Esc Enferm*, *50*(3), 509-518.

Aléx, L., & Hammarström, A. (2004). Women's experiences in connection with induced abortion—a feminist perspective. *Scandinavian Journal of Caring Science*, *18*(2), 160-168.

Altshuler, A. L., Nguyen, B. T., Riley, H. E., Tinsley, M. L. & Tuncalp, Ö. (2016). Male partners' involvement in abortion care: A mixed-methods systematic review. *Perspectives on Sexual and Reproductive Health*, *48*(4), 209-219.

Baker, A., & De Robertis, C. (2005). *Provoice: A framework for communicating personal experiences with abortion*. Retrieved from https://exhaleprovice.org/sites/default/files/users/aspen/ExhaleProVoiceFramework2005.pdf

BBC. (2012, November 14). Woman dies after abortion request 'refused' at Galway hospital. Retrieved from https://www.bbc.com/news/uk-northern-ireland-20321741

Bellefontaine, M. (2018, April 4). Alberta to introduce safe zones around abortion clinics. *CBC News*. Retrieved from https://www.cbc.ca/news/canada/edmonton/alberta-to-introduce-safe-zones-around-abortion-clinics-1.4605302

Berer, M. (2017). Abortion law and policy around the world: In search of decriminalization. *Health and Human Rights Journal*, *19*(1), 13-27.

Blanchfield, M. (2017, March 3). Liberals pledge $20M to fill abortion funding gap. *The Toronto Star*. Retrieved from https://www.thestar.com/news/canada/2017/03/02/liberals-pledge-up-to-20-million-for-sexual-health-funding-after-trump-cuts.html

Boston Women's Health Book Collective. (2011). *Our bodies, ourselves* (Rev. ed.). New York, NY: Simon & Schuster.

Bourgeois, S. (2014). Our bodies are our own: connecting abortion and social policy. *Canadian Review of Social Policy*, *70*, 22-33.

Boyer, Y. & Bartlett, J. (2017). *External review: Tubal ligation in the Saskatoon Health Region: The lived experience of Aboriginal women*. Retrieved from https://www.saskatoonhealthregion.ca/DocumentsInternal/Tubal_Ligation_intheSaskatoonHealthRegion_the_Lived_Experience_of_Aboriginal_Women_BoyerandBartlett_July_22_2017.pdf

Bruner, J. (1987). Life as narrative. *Social Research, 54*(1), 11-32.

Bunting, S. & Campbell, J. C. (1990). Feminism and nursing historical perspectives. *Advanced Nursing Science, 12*, 11-24.

Burton, C. W. (2016). The health needs of young women: Applying a feminist philosophical lens to nursing science and practice. *Advances in Nursing Science, 39*(2), 108-118.

Cain, C. (1991). Personal stories: Identity acquisition and self-understanding in Alcoholics Anonymous. *Ethos, 19*(2), 210-253.

Campbell, J. C. & Bunting, S. (1991). Voices and paradigms: Perspectives on critical and feminist theory in nursing. *Advances in Nursing Science, 13*(3), 1-15.

Canadian Agency for Drugs and Technologies in Health. (2017). *CADTH Canadian drug expert committee final recommendation: Mifepristone and misoprostol (Mifegymiso – Celopharma) Indication: Medical termination of pregnancy*. Retrieved from https://www.cadth.ca/sites/default/files/cdr/complete/SR0502_complete_Mifegymiso-Apr-20-17-e.pdf

Canadian Institute for Health Information (CIHI). (2014). Induced abortion reported in Canada in 2014 [Table]. Retrieved from https://www.cihi.ca/en/induced-abortions-reported-in-canada-in-2014

Canadian Institute for Health Information (CIHI). (2015, 2016, 2017). Induced abortion reported in Canada in 2015, 2016, 2017. [Tables]. Retrieved from: https://www.cihi.ca/en/search?query-all=abortion&Search+Submit

Cano, J. K. & Foster, A. M. (2016). "They made me go through like weeks of appointment and everything": Documenting women's experiences seeking abortion care in Yukon Territory, Canada. *Contraception, 94*(5), 489-495.

CBC News. (2018, February 1). Safe zones around abortion clinics now in place. *CBC News*. Retrieved from https://www.cbc.ca/news/canada/ottawa/ottawa-abortion-clinic-safe-zone-police-1.4510607

CBC News. (2019, April 4). Abortion pills replace demand for surgical termination of pregnancy at Victoria Clinic. *CBC News*. Retrieved from https://www.cbc.ca/news/canada/british-columbia/mifegymiso-abortion-pill-1.5083852

CEMACH (Confidential Enquiry into Maternal and Child Health). (2007). Saving mothers lives, reviewing maternal deaths to make motherhood safer 2003-2005. London: CEMACH.

Chinn, P. L. & Wheeler, C.E. (1985). Feminism and nursing. *Nursing Outlook*, *33*, 74-7.

Chinn, P. L. & Kramer, M. (2015). *Integrated knowledge development in nursing* (8th ed.). St. Louis, MO: Mosby.

Chinn, P. L. (2017). Chapter 7: Critical theory and emancipatory knowing. In J. B Butts & K. L. Rich (Eds.), *Philosophies and theories for advanced nursing practice* (pp. 289-327). Burlington, MA: Jones & Bartlett Learning.

Choice in Health Clinic. (2019). *FAQ*. Retrieved from http://www.choiceinhealth.ca/Public/FAQs

Clandinin, D. J., & Connelly, F. M. (2000). *Narrative Inquiry: Experience and Story in Qualitative Research*. San Francisco, CA: John Wiley & Sons, Inc.

Clandinin, D. J. (2013). *Engaging in Narrative Inquiry*. New York, NY: Left Coast Press, Inc.

Clementson, L. (2019, May 9). 'We pledge to make abortion unthinkable in our lifetime': PC MP Sam Oosterhoff. *CBC News*. Retrieved from https://www.cbc.ca/news/canada/hamilton/oosterhoff-abortion-1.5129494

College of Nurses of Ontario. (2017). What NPs should know about Mifegymiso. Retrieved from http://www.cno.org/en/news/2017/july-2017/what-nps-should-know-about-mifegymiso/

Coulter, M. (2010). Institution of motherhood. In A. O'Reilly (Ed.), *Encyclopedia of motherhood*. Thousand Oaks, CA: Sage.

Creswell, J. W., & Poth, C. N. (2017). *Qualitative Inquiry & Research Design: Choosing Among Five Approaches* (4th ed.). Thousand Oaks, CA: SAGE Publications.

Dennis, A., Manski, R. & Blanchard, K. (2015). A qualitative exploration of low-income women's experiences accessing abortion in Massachusetts. *Women's Health Issues*, *25*(5), 463-469.

Denzin, N. K. (1989). *Interpretive biography*. Newbury Park, CA: Sage.

DeVault, M. L., & Gross, G. (2012). Feminist qualitative interviewing: Experience, talk, and knowledge. In S. Nagy (Ed.), *Handbook of Feminist Research: Theory and Praxis* (pp.206-236). Thousand Oaks, California: SAGE Publications.

Deveau, A. (2017). Timeline of a maternal breakdown: A feminist mother's blog post about her abortion experience. In E. R. M. Lind & A. Deveau (Eds.), *Interrogating Pregnancy Loss: Feminist Writings on Abortion, Miscarriage, and Stillbirth* (pp. 40-46). Bradford, ON: Demeter Press.

Di Lapi, E. M. (1989). Lesbian mothers and the motherhood hierarchy. *Homosexuality and the Family, 18* (1-2), 101-121.

Doucet, A. & Mauthner, N. S. (2005). Feminist methodologies and epistemology. In *Nontraditional perspectives, theory, and methodology* (pp. 36-42). Retrieved from http://www.andreadoucet.com/wp-content/uploads/2010/11/Doucet-Mauthner-2005-Feminist-Methodologies-and-Epistemologies.pdf

Downe, P. J. (2004). Stepping on maternal ground: Reflections on becoming an "other-mother". In A. O'Reilly (Ed.) *Mother matters: Motherhood as discourse and practice* (pp.165-178). Toronto, ON: Association for Research on Mothering.

Downie, J., & Nassar, C. (2007). Barriers to access to abortion through a legal lens. *Health Law Journal*, *15*, 143-1

Dressler, J., Maughn, N., Soon, J. A., & Norman, W. V. (2013). The perspective of rural physicians providing abortion in Canada: Qualitative findings of the BC Abortion Providers Survey (BCAPS). *PLOS ONE*, *8*(6), 1-5.

Duffy, M. (2012). Narrative inquiry: The method. In P. L. Munhall (Ed.), *Nursing research: A qualitative primer* (pp. 421-440). Sudbury, MA: Jones & Bartlett Learning.

Dunn, S. & Cook, R. (2014). Medical abortion in Canada: behind the times. *CMAJ*, *186*(1), 13-14.

Duquaine-Watson, J. (2004). All you need is love: Representations of maternal emotion in Working Mother magazine 1995-1999. In A. O'Reilly (Ed.) *Mother matters: Motherhood as discourse and practice* (pp. 125-138). Toronto, Ontario: Association for Research on Mothering.

Dykes, K., Slade, P., & Haywood, A. (2011). Long term follow-up of emotional experiences after termination of pregnancy: women's views at menopause. *Journal of Reproductive and Infant Psychology*, *29*(1), 93-112.

Earle, S. Komaromy, C., Foley, P., & Lloyd, C. (2007). The social dimensions of reproductive loss. *Practising Midwife*, *10*(6), 28-34.

Earle, S. Foley, P., Komaromy, C., & Lloyd, C. (2008). Conceptualizing reproductive loss: A social sciences perspective. *Human Fertility*, *11*(4), 259-262.

Ehrenreich, B., & English, D. (2010). *Witches, midwives, & nurses: A history of women healers* (2nd ed.). New York, NY: Feminist Press.

Endemann, E. (2019, April 25). Anti-abortion ad on Ottawa bus angers two councillors. *Ottawa Citizen*. Retrieved from https://ottawacitizen.com/news/local-news/anti-abortion-ad-on-ottawa-bus-angers-two-councillors

Falk-Rafael, A. (2005a). Advancing nursing theory through theory-guided practice. *Advances in Nursing Science, 28*(1), 38-49.

Falk-Rafael, A. (2005b). Speaking truth to power: Nursing's legacy and moral imperative. *Advances in Nursing Science*, *28*(3), 212-223.

Falk-Rafael, A. & Betker, C. (2012). Witnessing social injustice downstream and advocating for health equity upstream: "The trombone slide" of nursing. *Advances in Nursing Science*, *35*(2), 98-112.

Foster, A. M, LaRoche, K, J., El-Haddad, J., Degroot, L. & El-Mowafi, I. M. (2017). "If I ever did have a daughter, I wouldn't raise her in New Brunswick:" exploring women's experiences obtaining abortion care before and after policy reform. *Contraception*, *95*(5), 477-484.

Fraser, L. (2017, August 11). You can't get the abortion pill without an ultrasound: A hurdle for rural doctors. *CBC News*. Retrieved from: https://www.cbc.ca/news/canada/toronto/abortion-pill-rural-access-1.4242666

Ganatra, B., Gerdts C., Rossier C. et al. (2017). Global, regional, and subregional classification of abortions by safety, 2010–14: estimates from a Bayesian hierarchical model. *The Lancet*, *390*(10110), 2372-2381.

Georges, J. M. (2005). Linking nursing theory and practice: A critical-feminist approach. *Advances in Nursing Science*, *29*(1), 50-57.

Gordon, K. & Thain, A. (2018, October 9). Reconsidering abortion 30 years after Morgentaler. *The Toronto Star*. Retrieved from https://www.thestar.com/opinion/contributors/2018/10/09/reconsidering-abortion-30-years-after-morgentaler.html

Government of Canada (2016, January 08). *Summary basis of decision – Mifegymiso – Health Canada*. Retrieved from https://hpr-rps.hres.ca/reg-content/summary-basis-decision-detailTwo.php?linkID=SBD00239

Government of Canada. (2019, April 16). *Health Canada approves updates to Mifegymiso prescribing information: Ultrasound no longer mandatory*. Retrieved from https://healthycanadians.gc.ca/recall-alert-rappel-avis/hc-sc/2019/69620a-eng.php

Government of Canada. (2019, May 02). *Sexual and reproductive health and rights*. Retrieved from https://www.international.gc.ca/world-monde/issues_development-enjeux_developpement/global_health-sante_mondiale/reproductive-reproductifs.aspx?lang=eng

Grant, K. (2017, April 19). Canadian rollout of abortion pill stalls amid distribution confusion, lack of drug coverage. *The Globe and Mail*. Retrieved from: https://www.theglobeandmail.com/news/national/abortion-pills-canadian-launch-delayed-by-lack-of-coverage-distribution-rules/article34181063/

Grant, K. (2019, March 29). Why the only abortion clinic on Vancouver Island has stopped offering surgical abortions. *The Globe and Mail*. Retrieved from: https://www.theglobeandmail.com/canada/article-why-the-only-abortion-clinic-on-vancouver-island-has-stopped-offering/

Gustafson, D. L. & Porter, M. (2014). Exploring how women think about and make their reproductive choices: A generational approach. In S. Paterson, F. Scala & M. K. Sokolon (Eds.) *Fertile Ground* (pp. 19-47). Montreal & Kingston: McGill-Queen's University Press.

Guttmacher Institute. (2018, December 11). *State abortion policy landscape: From hostile to supportive*. Retrieved from https://www.guttmacher.org/article/2018/12/state-abortion-policy-landscape-hostile-supportive

Hall, J. M. & Carlson, K. (2016). Marginalization: A revisitation with integration of scholarship on globalization, intersectionality, privilege, microaggressions, and implicit biases. *Advances in Nursing Science, 39*(3), 200-215.

Harris, K. (2017, March 8). Justin Trudeau marks International Women's Day with $650M for reproductive rights. *CBC News*. Retrieved from http://www.cbc.ca/news/politics/trudeau-women-reproductive-rights-1.4014841

Haydon, G., & van der Riet, P. (2016). Narrative inquiry: A relational research methodology suitable to explore narrative of health and illness. *Nordic Journal of Nursing Research, 37*(2), 85-89.

Hesse-Biber, S. N. (Ed.) (2014a). *Feminist research practice: A primer* (2nd ed.). Thousand Oaks, CA: Sage.

Hesse-Biber, S. N. (2014b). Feminist research: Exploring, interrogating, and transforming the interconnections of epistemology, methodology, and method. In Hesse-Biber, S. N. (Ed.). *Handbook of feminist research: Theory and praxis* (pp. 2-26). Thousand Oaks, CA: SAGE

hooks, b. (2000). *Feminism is for everybody: Passionate politics.* Cambridge, MA: South End Press

House, J. (1981). *Work stress and social support*. Reading, MA: Addison-Wesley

Hudes, S. (2017, August 17). Abortion pill now free in Ontario, but still hard to find. *Toronto Star*. Retrieved from https://www.thestar.com/news/gta/2017/08/17/abortion-pill-now-free-in-ontario-but-still-hard-to-find.html

Huntington, A. D. (2002). Working with women experiencing mid-trimester termination of pregnancy: the integration of nursing and feminist knowledge in the gynaecological setting. *Journal of Clinical Nursing, 11*(2), 273-279.

Hurley, C. (2016). T.A. In Stettner, S. (Ed.) *Without apology: Writings on abortion in Canada* (pp. 83-89). Edmonton, AB: AU Press Athabasca University.

Ibrahim, H. (2018, July 31). Anti-abortion centre reopens next door to Clinic 554. *CBC News*. Retrieved from https://www.cbc.ca/news/canada/new-brunswick/right-to-life-clinic-554-abortion-1.4768481

Im, E. (2010). Current trends in feminist nursing research. *Nursing Outlook, 58*(2), 87-96.

Janiak, E., & Goldberg, A.B. (2016). Eliminating the phrase “elective abortion”: why language matters. *Contraception, 93*(2), 89-92.

Jonas-Simpson, C. & McMahon, E. (2005). The language of loss when a baby dies prior to birth: Cocreating human experiences. *Nursing Science Quarterly, 18*(2), 124-130.

Jones, R. K. & Henshaw, S. K. (2002). Mifepristone for early medical abortion: Experiences in France, Great Britain, and Sweden. *Perspectives of Sexual and Reproductive Health, 34*(3), 154-161.

Jones, R. K., Frohwirth, L. F., & Moore, A. M. (2008). "I would want to give my child, like, everything in the world". *Journal of Family Issues*, *29*(1), 79-99.

Kagan, P. N., Smith, M. C., Richard Cowling III, W., & Chinn, P. L. (2009). A nursing manifesto: an emancipatory call for knowledge development, conscience, and praxis. *Nursing Philosophy*, *11*(1), 67-84.

Kaposy, C. (2009). The public funding of abortion in Canada: going beyond the concept of medical necessity. *Medicine, Health Care, and Philosophy, 12*(3), 301-311.

Kaposy, C. (2010). Improving abortion access in Canada. *Health Care Analysis, 18*(1), 17-34.

Kawash, S. (2011). New directions in motherhood studies. *Signs: Journal of Women in Culture & Society, 36*(4), 969-1003.

Kelly, T. & Howie, L. (2007). Working with stories in nursing research: procedures used in narrative analysis. *International Journal of Mental Health Nursing, 16*(2), 136-144.

Kimport, K., Perrucci, A., & Weitz, T. A. (2012). Addressing the silence in the noise: How abortion support talklines meet some women's needs for non-political discussion of their experiences. *Women & Health, 52*(1), 88-100.

Kjelsvik, M., Tveit Sekse, R. J., Litleré Moi, A., Aasen, E. M., Chesla, C. A., & Gjengedal, E. (2018). Women's experiences when unsure about whether or not to have an abortion in the first trimester. *Health Care for Women International*, *39*(7), 784-807.

Kluger-Bell, K. (1998). *Unspeakable losses: Healing from miscarriage, abortion, and other pregnancy loss*. New York, NY: Harper.

Latt, S. M., Milner, A., & Kavanagh, A. (2019). Abortion laws reform may reduce maternal mortality: an ecological study in 162 countries. *BMC Women's Health*, *19*(1), 1-9.

Layne, L. L. (2003). Unhappy endings: a feminist reappraisal of the women's health movement from the vantage of pregnancy loss. *Social Science & Medicine, 56*(9), 1881-1891.

Leeder, J. (2018, September 22). I wanted an abortion in Nova Scotia, but all around, barriers still remained. *The Globe and Mail*. Retrieved from https://www.theglobeandmail.com/opinion/article-i-wanted-an-abortion-in-nova-scotia-but-all-around-barriers-still/

Letherby, G. (2002). Childless and bereft? Stereotypes and realities in relation to 'voluntary' and 'involuntary' childlessness and womanhood. *Sociological Inquiry*, *72*(1), 7-20

Lie, M. L. S., Robson, S. C., & May, C. R. (2008). Experiences of abortion: A narrative review of qualitative studies. *BMC Health Services Research, 8*, 150.

Lincoln, Y. S. & Guba, E. G. (1985). *Naturalistic inquiry*. Newbury Park, CA: Sage.

Lind, E. R. M. & Deveau, A. (Eds.) (2017). *Interrogating pregnancy loss: Feminist writings on abortion, miscarriage, and stillbirth*. Bradford, ON: Demeter Press.

Lipp, A. (2008a). A woman centred service in termination of pregnancy: A grounded theory study. *Contemporary Nurse*, *31*(1), 9-19.

Lipp, A. (2008b). A review of termination of pregnancy: prevalent health care professional attitudes and ways of influencing them. *Journal of Clinical Nursing*, *17*(3), 1683-1688.

Lippman, A. (2014). Foreword. In S. Paterson, F. Scala & M. K. Sokolon (Eds.) *Fertile ground* (pp. xiii-xv). Montreal & Kingston: McGill-Queen's University Press.

Longo, J. & Dunphy, L. M. (2012). Postmodern philosophy and qualitative research. In Munhall, P. L. (Ed.), *Nursing research: A qualitative primer* (pp.95-109). Sudbury, MA: Jones & Bartlett Learning.

Lovett, L. L. (2010). Pronatalism. In A. O'Reilly (Ed.), *Encyclopedia of motherhood*. Thousand Oaks, CA: Sage.

Lowik, A. J. (2017). Trans-inclusive abortion services: A manual for providers on operationalizing trans-inclusive policies and practices in an abortion setting. Retrieved from http://www.fqpn.qc.ca/main/wp-content/uploads/2017/12/FQPN-Manual-EN-Web.pdf

Luna, Z. T. (2011). "The phrase of the day": Examining contexts and co-optation of reproductive justice activism in the women's movement. In A. C. Snyder & S. P. Stobbe (Eds.), *Critical aspects of gender in conflict resolution, peacebuilding, and social movements* (pp. 219-249). Winnipeg, MB: Emerald.

MacDonnell, J. A. (2001). "Facilitating support for expectant lesbians in a public health context: Encountering resistance in the research process." *Journal of the Association for Research on Mothering*, *3*(1), 109-120.

MacDonnell, J. A. (2006). Exploring matrices of mothering and feminism: Understanding mothering discourses for lesbian health advocates through life histories. *Journal of the Association for Research on Mothering*, *8*(1, 2), 298-310

MacDonnell, J. A. & Andrews, G. J. (2006). Placing sexuality in health policies: feminist geographies and public health nursing. *GeoJournal*, *65*(4), 349-364.

MacDonnell, J. A. (2014). Enhancing our understanding of emancipatory nursing: A reflection on the use of critical feminist methodologies. *Advances in Nursing Science*, *37*(3), 271-280.

MacQuarrie, C. (2016). “We can get there faster if we all move together”: The birth and evolution of a reproductive justice activist. In S. Stettner (Ed.) *Without apology: Writings on abortion in Canada* (pp. 157-162). Edmonton, AB: AU Press Athabasca University.

MacPherson, K. L. (1983). Feminist methods a new paradigm for nursing research. *Advances in Nursing Science, 5*(2), 17-25.

Mah, A. (2017, December 28). Abortion clinic says patients, staff at breaking point over protester intimidation. *Ottawa Citizen*. Retrieved from https://ottawacitizen.com/news/local-news/ottawa-abortion-clinic-says-patients-staff-at-breaking-point-over-protester-intimidation

Maher, J. & Mohammed, S. (2015). “Our words, our health”: The continuing value of including women in health research and knowledge translation. In P. Armstrong & A. Pederson (Eds.) *Women’s health: Intersections of policy, research, and practice* (pp. 328-343). Toronto, ON: Women’s Press.

Makenzius, M., Tydén, T., Darj, E., & Larsson, M. (2013). Autonomy and dependence – experiences of home abortion, contraception and prevention. *Scandinavian Journal of Caring Science, 27*(3), 569-579.

Mallick, H. (2017, January 13). After anti-abortion ads on buses, what’s next?: Mallick. *The Toronto Star*. Retrieved from https://www.thestar.com/news/gta/2017/01/13/after-anti-abortion-ads-on-buses-whats-next-mallick.html

McIntyre, M., Anderson, B., & McDonald, C. (2001). The intersection of relational and cultural narratives: Women’s abortion experiences. *Canadian Journal of Nursing Research, 33*(3), 47-62.

McLemore, M. & Levi, A. (2011). Nurses and care of women seeking abortions, 1971-2011. *Journal of Gynecology and Neonatal Nursing*, *40*(6), 672-677.

Medoff, M. (2016). Pro-choice versus pro-life: The relationship between state abortion policy and child well-being in the United States. *Health Care for Women International*, *37*(2), 158-169.

Ministry of Health and Long Term Care. (2014). *Independent Health Facilities Act.* Retrieved from http://www.health.gov.on.ca/en/public/programs/ihf/docs/ihf_fact.pdf

Ministry of Health and Long Term Care. (2017). *Abortion Pill Available at No Cost: Province Providing More Reproductive Choice for Women with Access to Mifegymiso*. Retrieved from https://news.ontario.ca/mohltc/en/2017/08/abortion-pill-available-across-ontario-at-no-cost.html

Mitchell, K. (2018, October 11). "You just have to rely on yourself…": Experiences of barriers to abortion information and services in Southern Alberta. PowerPoint Presentation at Abortion Beyond Bounds Conference, McGill University, Montreal, QC.

Modh, C., Lundgren, I., & Bergbom, I. (2011). First time pregnant women's experiences in early pregnancy. *International Journal of Qualitative Studies on Health & Well-Being*, *6*(2), 1-11.

Moore, J. (2018). From "I'm never having children" to motherhood: A critical analysis of silence and voice in negotiations of childbearing face. *Women's Studies in Communication*, *41(*1), 1-21.

Mother. (n.d.) In Oxford Learner's Dictionary. Retrieved from https://www.oxfordlearnersdictionaries.com/us/definition/english/mother_1?q=mother

Motherhood Initiative for Research and Community Involvement (MIRCI). (2019). Retrieved from https://motherhoodinitiative.org/

Mullan, E. (2016). Countering Same with Compassion: The role of the abortion counsellor. In S. Stettner (Ed.) *Without Apology: Writings on Abortion* (pp. 247-254). Edmonton, AB: AU Press Athabasca University.

Myers, A. & Nevill, M. (2010). Abortion: Offering advice and support to young men. *British Journal of School Nursing*, *5*(5), 235-238.

Nash, E. (2019). *A surge in bans on abortion as early as six weeks, before most people know they are pregnant*. Retrieved from https://www.guttmacher.org/article/2019/03/surge-bans-abortion-early-six-weeks-most-people-know-they-are-pregnant

National Abortion Federation. (2019). *Abortion coverage by region*. Retrieved from http://www.nafcanada.org/access-region.html

Nguyen, B. T., Hebert, L. E., Newton, S. L., & Gilliam, M. L. (2018). Supporting women at the time of abortion: A mixed-methods study of male partner experiences and perspectives. *Perspectives on Sexual and Reproductive Health*, *50*(2), 75-83.

Norman, W. V. (2012). Induced abortion in Canada 1974-2005: Trends over the first generation with legal access. *Contraception*, *85*, 185-191.

Norman, W. V., Soon, J. A., Maughn, N. & Dressler, J. (2013). Barriers to rural induced abortion services in Canada: Findings of the British Columbia Abortion Providers Survey. *PloS ONE*, *8*(6), e67023.

Oakley, A. (1981). Interviewing women: A contradiction in terms. In H. Roberts (Ed.), *Doing feminist research* (pp. 30-61). London, England: Routledge & Kegan Paul.

O'Reilly, A. (2004a). Introduction. In A. O'Reilly (Ed.) *Mother matters: Motherhood as discourse and practice* (pp.11-26). Toronto, ON: Association for Research on Mothering.

O'Reilly, A. (2004b). Labour Signs: The semiotics of birthing. In O'Reilly, A. (Ed.) *Mother matters: Motherhood as discourse and practice* (pp.29-36). Toronto, ON: Association for Research on Mothering.

Papworth, V. (2011). Abortion services: The need to include men in care provision. *Nursing Standard, 25*(4), 35-37.

Paterson, S., Scala, F., & Sokolon, M. K. (2014). Introduction. In S. Paterson, F. Scala, & M. K. Sokolon (Eds.), *Fertile ground: Exploring reproduction in Canada* (pp. 3-16). Montreal, QC & Kingston, ON: McGill-Queen's University Press.

Personal Narratives Group. (1989). *Interpreting Women's Lives: Feminist Theory and Personal Narratives.* Bloomington & Indianapolis, IN: Indiana University Press.

Pietsch, N. (2004). Un/titled: Constructions of illegitimate motherhood as gender insurrection. In A. O'Reilly (Ed.) *Mother matters: Motherhood as discourse and practice* (pp.65-78). Toronto, ON: Association for Research on Mothering.

Pitre, N. Y., Kushner, K. E., Raine, K., D. & Hegadoren, K. M. (2013). Critical feminist narrative inquiry: Advancing knowledge through double-hermeneutic narrative analysis. *Advances in Nursing Science, 36*(2), 118-132.

Polit, D. F., & Beck, C. T. (2012). *Nursing Research: Generating and Assessing Evidence for Nursing Practice*. Philadelphia, PA: Lippincott Williams & Wilkins.

Poole, N., Bopp, J., & Greaves, L. (2014). Provoking gender-transformative health promotion. In L. Greaves, A. Pederson, & N. Poole (Eds.) *Making it better: Gender-transformative health promotion* (pp. 195-211). Toronto, ON: Canadian Scholars' Press/Women's Press.

Porter M. & Gustafson, D. L. (2012). *Reproducing women: Family and health work across three generations*. Black Point, NS: Fernwood Books.

Purdy, L. (2006). Women's reproductive autonomy: Medicalisation and beyond. *Journal of Medical Ethics*, *32*(5), 287-291.

REAL Women of Canada. (2016). Retrieved from https://www.realwomenofcanada.ca

Registered Nurses Association of Ontario (RNAO). (2004). *Position Statement: Homelessness.* Retrieved from https://rnao.ca/policy/position-statements/homelessness

Registered Nurses Association of Ontario (RNAO). (2007). *Position Statement: Respecting sexual orientation and gender identity*. Retrieved from https://rnao.ca/policy/position-statements/sexual-orientation-gender-identity

Registered Nurses Association of Ontario (RNAO). (2018). *RNAO continues to advocate for RN prescribing*. Retrieved from https://rnao.ca/news/rnao-continues-advocate-rn-prescribing

Registered Nurses Association of Ontario (RNAO). (2018). *Ontario needs a modernized sexual education curriculum: Sign the alert*. Retrieved from https://rnao.ca/news/ontarians-need-modernized-sexual-education-curriculum-sign-action-alert

Riessman, C. K. (1987). When gender is not enough: Women interviewing women. *Gender & Society, 1*, 172-207.

Riessman, C. K. (1993). *Narrative Analysis*. Thousand Oaks, CA: Sage.

Riessman, C. K. (2008). *Narrative Methods for the Human Sciences*. Thousand Oaks, CA: Sage Publications.

Roberts, S. (2016). Waves of change in Prince Edward Island: Opening the dialogue on abortion access. In S. Stettner (Ed.) *Without apology: Writings on abortion in Canada* (pp. 163-166). Edmonton, AB: AU Press Athabasca University.

Rodgers, S. & Downie, J. (2006). Abortion: Ensuring access. *Canadian Medical Association Journal*, *175*(1), 9.

RTE. (2018, Dec 20). *Abortion legalised in Ireland after President signs bill*. Retrieved from https://www.rte.ie/news/2018/1220/1018402-abortion-bill/

Rubin, G. (1984). Thinking sex: Notes from a radical theory of the politics of sexuality. In C. Vance (Ed.), *Pleasure and danger: Exploring female sexuality* (pp. 267-319). Boston, MA: Routledge & Kegan Paul.

Sandelowski, M. (1991). Telling stories; Narrative approaches in qualitative research. *Journal of Nursing Scholarship*, *23*, 161-166.

Saurette, P. & Gordon, K. (2013). Arguing abortion: The new anti-abortion discourse in Canada. *Canadian Journal of Political Science*, *46*(1), 157-185.

Saurette, P. & Gordon, K. (2015). *The changing voice of the anti-abortion movement: The rise of "pro-woman" rhetoric in Canada and the United States.* Toronto, ON: University of Toronto Press.

Scheer, V. L., Steven, P. E., & Mkandawire-Valhmu, L. (2016). Raising questions about capitalist globalization and universalizing views on women: A transnational feminist critique of the World Development Report: Gender Equality and Development. *Advances in Nursing Science*, *39*(2), 96-107.

Sethna, C. & Doull, M. (2013). Spatial disparities and travel to freestanding abortion clinics in Canada. *Women's Studies International Forum*, *38*(Complete), 52-62.

Sex Information and Education Council of Canada. (2019). *Canadian Guidelines for Sexual Health Education*. Retrieved from http://sieccan.org/sexual-health-education/

Shaw, J. (2013). Full-spectrum reproductive justice: The affinity of abortion rights and birth activism. *Studies in Social Justice*, *7*(1), 143-159.

Shaw, J. & Downie, J. (2014). Welcome to the wild, wild, north: Conscientious objection policies governing Canada's medical, nursing, pharmacy, and dental professions. *Bioethics*, *28*(1), 33-46.

Smith, A. (2005). "Beyond pro-choice versus pro-life: Women of color and reproductive justice." *National Women's Studies Association Journal*, *17*(1), 119-40.

Smith Cross, J. (2017 April 28). Ontario making abortion pill free for all who need it. *The Canadian Press*. Retrieved from: http://www.ctvnews.ca/canada/ontario-making-abortion-pill-mifegymiso-free-for-all-who-need-it-1.3389935

Solnit, R. (2017). *The Mother of All Questions*. Chicago, IL: Haymarket Books.

Speier, D. S. (2004). Becoming a mother. In A. O'Reilly (Ed.) *Mother matters: Motherhood as discourse and practice* (pp.141-153). Toronto, ON: Association for Research on Mothering.

Sprague, J. (2016). *Feminist methodologies for critical researchers: Bridging difference* (2nd ed). Lanham, Maryland: Rowman and Littlefield.

Star Editorial Board. (2017, March 7). Clear obstacles to accessing the abortion pill in Canada: Editorial. *The Toronto Star*. Retrieved from https://www.thestar.com/opinion/editorials/2017/03/07/clear-obstacles-to-accessing-the-abortion-pill-in-canada-editorial.html

Stettner, S. (2013). "We are forced to declare war": linkages between the 1970 abortion caravan and women's anti-Vietnam war activism. *Social History*, *XLVI* (92), 423-441.

Stettner, S. (2016). The unfinished revolution. In Stettner, S. (Ed.) *Without apology: Writings on abortion in Canada* (pp. 333-347). Edmonton, AB: AU Press Athabasca University.

Stettner, S. & "Dr. James". (2016). On becoming an abortion provider: An interview. In s. Stettner, (Ed.) *Without apology: Writings on abortion in Canada* (pp. 261-273). Edmonton, AB: AU Press Athabasca University.

Taft, C. (2012, April 3). Reproductive rights: Sinking or swimming? *On the Issues*. Retrieved from https://www.ontheissuesmagazine.com/2012winter/cafe2.php?id=206

Tanner, A. (2006). Letter to the editor: Response to "The long-term phenomena of women's postabortion experiences". *Western Journal of Nursing Research*, *28*(3), 352-353.

Thompson, M. (2017). Believing is seeing is believing: Elective abortion and visual closure. In E. R. M. Lind & A. Deveau (Eds.) *Interrogating pregnancy loss: Feminist writings on abortion, miscarriage, and stillbirth* (pp.61-75). Bradford, ON: Demeter Press.

Timpson, J. (1996). Abortion: the antithesis of womanhood? *Journal of Advanced Nursing*, *23*, 776-785.

Tisdale, S. (1987). We do abortions here: A nurse's story. *Harper's Magazine*, *October*, 66-70.

Trybulski, J. (2005). The long-term phenomena of women's post-abortion experiences. *Western Journal of Nursing Research*, *27*(5), 559-578.

Trybulski, J. (2006a). Women and abortion: the past reaches into the present. *Journal of Advanced Nursing*, *54*(6), 683-690.

Trybulski, J. (2006b). Reply to the letter to the editor. *Western Journal of Nursing Research*, *28*(3), 354-356.

University of California Santa Barbara (2019). *Bodily autonomy*. Retrieved from http://www.soc.ucsb.edu/sexinfo/article/bodily-autonomy

Van Herk, K. A., Smith, D., & Andrew, C. (2010). Examining our privileges and oppressions: incorporating an intersectionality paradigm into nursing. *Nursing Inquiry*, *18*(1), 29-39.

Vogel, L. (2012). Sex-selective abortions: no simple solution. *CMAJ*, *184*(3), 286-288.

Vogel, L. (2015). Abortion access grim in English Canada. *CMAJ*, *187*(1), 17.

Vogel, K., LaRoche, K. J., El-Haddad, J., Chaumont, A., & Foster, A. M. (2016). Exploring Canadian women's knowledge of and interest in mifepristone: results from a national qualitative study with abortion patients. *Contraception*, *94*, 137-142.

Walks, M. (2014). Stratified reproduction: Making the case for butch lesbians', transmen's and genderqueer individuals' experiences in British Columbia. In S. Paterson, F. Scala & M. K. Sokolon (Eds.), *Fertile ground* (pp. 74-93). Montreal & Kingston: McGill-Queen's University Press.

Watson, J. (2008). Nursing: *The Philosophy and Science of Caring*. Boulder, CO: University of Colorado Press.

Webb, C. (1984). Feminist methodology in nursing research. *Journal of Advanced Nursing*, *9*, 249-256.

Weeks, C. (2019, June 7). Saskatchewan latest province to announce it will fund abortion pill Mifegymiso. *The Globe and Mail*. Retrieved from https://www.theglobeandmail.com/canada/article-saskatchewan-latest-province-to-announce-it-will-fund-abortion-pill/

Weitz, T. A., Moore, K., Gordon, R., & Adler, N. (2008). You say "regret" and I say "relief": a need to break the polemic about abortion. *Contraception*, *78*(2), 87-89.

Wershler, L. (2016). Pro-choice with no “but”: Three commentaries. In S. Stettner (Ed.) *Without apology: Writings on abortion in Canada* (pp.191-200). Edmonton, AB: AU Press Athabasca University.

Wesp, L. (2018). An emancipatory approach to cultural competency: The application of critical race, postcolonial, and intersectional theories. *Advances in Nursing Science, 41*(4), 316-326.

Wiebe, E., Najafi, R., Soheil, N., Kamani, A. (2011). Muslim women having abortions in Canada: Attitudes, beliefs, and experiences. *Canadian Family Physician*, 57, e134-138.

Wiebe, E., Chalmers, A., & Yager, H. (2012). Delayed motherhood: Understanding the experiences of women older than age 33 who are having abortions but plan to become mothers later. *Canadian Family Physician, 58*, e588-95.

Williams, J. C. & Shames, S. L. (2004). Mothers’ dreams: Abortion and the high price of motherhood. *University of Pennsylvania Journal of Constitutional Law*, *6(*4), 818-843.

Winnikoff, B., & Sheldon, W. (2012). Use of medicines changing the face of abortion. *International Perspectives on Sexual and Reproductive Health*, *38*(3), 164-166

World Health Organization. (2015). *Safe abortion: Technical and policy guidance for health systems*. Retrieved from https://www.who.int/reproductivehealth/publications/unsafe_abortion/sa_legal_policy_considerations/en/

World Health Organization. (2016). *Expanding health worker roles for safe abortion in the first trimester of pregnancy*. Retrieved from https://www.who.int/reproductivehealth/publications/unsafe_abortion/health-worker-roles-safe-abortion-1st-trimester-summary/en/

World Health Organization. (2018, Feb 19). *Preventing Unsafe Abortion*. Retrieved from https://www.who.int/en/news-room/fact-sheets/detail/preventing-unsafe-abortion

Wu, F. & Arthur, J. (2010). *A survey of anti-choice protesting activity at Canadian abortion clinics*. Vancouver, BC: Abortion Rights Coalition of Canada. Retrieved from hhtp://www.arcc-cdac.ca/presentations/ARCC-survey-protest-activity.pdf

Yasseen III, A. S. & Lacaze-Masmoneil, T. (2016). Male-biased infant sex ratios and patterns of induced abortion. *CMAJ*, *188*(9), 640-641.

Zingel, A. (2019, April 25). Removal of ultrasound requirement could improve access in remote communities to abortion drug. *CBC News*. Retrieved from https://www.cbc.ca/news/canada/north/abortion-pill-ultrasound-access-1.5110044

Appendices

Appendix A - Recruitment Poster

Looking for mothers to share their experiences of abortion

Are you:

- **A mother, over the age of 18, living in Ontario,**
- **And, you made the decision to have an abortion (either by procedure or by abortion pill) in the last 2 years?**

If you answered yes to the above questions, you are invited to volunteer for this study of Ontario mothers' contemporary experiences accessing abortion.

You will be asked to participate in an interview and to tell your story of abortion.

Your participation will include one interview, and the chance, if you wish, to review the story that you told the interviewer. The time expected for the interview is about 1 hour.

In appreciation for your time, you will receive $20 in the form of coffee gift card and be reimbursed $20 to cover childcare and/or transportation costs.

If you are interested in participating in this study or for more information please contact:

Margaret Lebold, Registered Nurse (RN), Master of Nursing Student, York University
Faculty of Graduate Studies, School of Nursing

This research study has been reviewed and approved by the Faculty of Graduate Studies at York University and the York University Research Ethics Board.

Appendix B - In-Person Script

Hi,

My name is Margaret Lebold. I am a registered nurse and Masters of Nursing student at York University in the Faculty of Graduate Studies, School of Nursing. I am contacting you to see if you might be interested in participating in a research study.

This research is being done as part of my Masters project and my thesis supervisor's name is Judith MacDonnell. The focus of the research is to understand mothers' experiences accessing abortion in Ontario.

To participate, you need to be a mother, over the age of 18, and have made the decision to have an abortion (e.g., an elective abortion and not an abortion needed for medical reasons). The abortion could be either by procedure or by abortion pill.

Your participation will involve one interview that will be conducted in a private setting. You will also have the opportunity to review your story as understood by the researcher. Your information will remain confidential, and your identity and the identity of the abortion clinic and your abortion care provider will be concealed in the research reporting.

In appreciation for your time, you will receive $20 in the form of coffee gift card and be reimbursed $20 to cover childcare and/or transportation costs.

Your participation is completely voluntary, and if you choose not to participate, it will not affect your relationship now, or in the future, with any abortion clinic, or York University.

The research has been reviewed and approved by the Faculty of Graduate Studies at York University and the York University Research Ethics Board.

If you are interested in more information about the study or would like to volunteer to take part in the study, please reply by e-mail.

Appendix C - Informed Consent Form

Canadian Mothers' Contemporary Experiences Accessing Abortion

Researchers:
Margaret Lebold, RN, BScN (Student, Masters of Science in Nursing Program at York University)
Supervisor: Dr. Judith MacDonnell, Associate Professor, School of Nursing, York University

Introduction:
You are being invited to participate in a research study looking at Canadian mothers' recent experiences with abortion access. Before agreeing to participate in the study, it is important that you read and understand the information contained in the consent. The informed consent contains information that you need to know and understand in order to decide whether you wish to participate in the study. If you have any questions or would like clarification about the study, please contact the researchers. Only after reading through the informed consent in full, and understanding its contents, should you sign below.

The purpose of the study:
The purpose of the study is to examine Canadian mothers' contemporary experiences accessing abortion.

Eligibility:
You are eligible to participate in this study if you identify currently self-identify as a mother over the age of 18 AND have experienced an elective abortion in the last **2 years.**

What you will be asked to do in the research:
Should you volunteer for this research, you will be asked to participate in a 60-90 minute interview with the researcher. You will be asked for your consent to be audiotaped during the interview.

The interview will ask you to share your abortion experience as a mother. The interview will allow you to explore and tell your story in any way that you wish to tell it. In addition to the story that you share, the interview may also ask about your specific experiences accessing abortion; and ask you to share details of the facilitators and barriers to access, and details about being a mother and having an abortion.

Potential risks and discomforts to you as a participant:
No harm is intended as part of this study. However, it is possible that the research topic may provoke undesirable feelings of discomfort or grief. Recognizing this possibility, you will be encouraged to share your abortion/motherhood story in ways that feel uniquely comfortable to you. You may choose to limit what you share at any time during the study. Participation in the study is completely voluntary. You may choose to not answer a question, or withdraw for the study at any time without penalty. A list of no-cost counselling resources will be made available to all participants.

Potential benefits:
There may not be any direct benefits to you by participating in this research. However, this information may present an opportunity for you to share details of your abortion experiences and/or the conditions of motherhood in Canada. Your participation in this research may contribute to future implications for mothers' and women's continued full-spectrum reproductive rights in Canada. Your participation may have implications for nursing practice. For instance, it may inform the ways in which nurses and health care professionals understand and consider mothers' abortion experiences in their practice.

Voluntary participation:
Your participation in the research is completely voluntary and you may choose to stop participating at any time. Your decision to not continue participating will not influence your relationship or the nature of your relationship with the researchers or with staff at York University, either now, or in the future.

Withdrawal from the study:
You may stop participating in the study at any time, for any reason, if you so decide. Your decision to stop participating, or to refuse to answer particular questions, will not affect your relationship with the researchers, York University, the abortion clinics or providers, or any other group associated with this project. In the event that you withdraw from the study, all associated data collected will be immediately destroyed wherever possible.

Confidentiality:
Your identity and the identity of the abortion clinic will only be known to the researcher(s), and will not be disclosed in the reporting of research findings. Identifying information will be safeguarded by encryption and password protection (e.g., informed consent). Pseudonyms will be used to identify you and any quoted material you provide, in all reports, and presentations made based on this research.

The interview will take place in a mutually convenient, private, secure, and confidential setting agreed upon by you and the researcher. Accommodations will be made for participants who may prefer to interview via skype/zoom technology and cannot arrange to meet in person. The interview will be taped and transcribed. You have the right to review/edit the recordings or transcripts.

All data will be safely stored in a locked facility for 5 years, and only the graduate researcher and research supervisor will have access to this information. After 5 years, the files will be destroyed. Paper data including consents will be shredded; the confidential transcripts will be erased and electronic files deleted.

Participation in this study is completely separate from your medical record. Your participation in this study will not be linked with your medical history, electronic medical record, or any file you may have.

Confidentiality will be provided to the fullest extent possible by law.

Incentives for Participation:
In appreciation for your time, you will receive $20 in the form of coffee gift card and be reimbursed $20 to cover childcare and/or transportation costs.

Costs to Participate:
You may incur costs to participate in time and travel. Allocations have been made to reimburse you for your voluntary participation, as listed above.

Questions about the research?
If you have any questions about the research in general, or your role in the study, you should contact Margaret Lebold, RN, BScN, MScN Student, or Dr. Judith MacDonnell, RN, PhD, Graduate Student Supervisor, by e-mail. This research has been approved by the York University Faculty of Graduate Studies, Human Participants Review Sub Committee, York University's Ethics Review Board, and conforms to the stands of the Canadian Tri-Council Research Ethics Guidelines. If you have any questions about this process or about your rights as a participant in this study, you may contact the Senior Manager and Policy Advisor for the Office of Research Ethics.

Legal Rights and Signatures:
I, _____, consent to participate in the study entitled **Canadian Mothers' Contemporary Experiences Accessing Abortion** conducted by nursing graduate student, Margaret Lebold with supervision from Dr. Judith MacDonnell. I have understood the nature of this project and wish to participate. I am not waiving any of my legal rights by signing this form. My signature below indicates my consent.

Furthermore, I consent to be audiotaped in the study interview and understand that the audio recording will be transcribed and will be permanently deleted after transcription.

Participant name: _____
Participant signature: _____
Date: _____

Principal Investigator name: _____
Principal Investigator signature: _____
Date: _____

Appendix D - Verbal Informed Consent Script

The following verbal informed consent will be used in the event that a participant chooses to participate via Skype or Zoom versus in-person, and who cannot provide a written informed consent. In this case, the form will be read verbatim.

You are being invited to participate in a research study looking at Canadian mothers' recent experiences with abortion access. The study is called 'Canadian Mothers' Contemporary Experiences Accessing Abortion' and is being conducted by myself, Margaret Lebold (a registered nurse (RN) and Masters student in the school of nursing at York University). If you have any questions or concerns about the study, I can be contacted by e-mail or via the office of graduate studies at York University. I am being supervised by Dr. Judith MacDonnell, Associate Professor in the School of Nursing at York University. Dr. MacDonnell can be reached by e-mail.

Before agreeing to participate in the study, it is important that you understand the information that I will read to you now, which comprises the informed consent and replaces a written consent form. This verbal informed consent contains information that you need to know and understand in order to decide whether you wish to participate in the study. If you have any questions or would like clarification about the study, please contact myself, or Dr. Judith MacDonnell. Only after listening to the informed consent in full, and understanding its contents, should you agree to participate. If you agree to participate, I, the researcher, will record your name, the date and time you agreed to the consent, and keep this information on a password protected file, on an encrypted USB to fulfill the requirements of maintaining a record of obtained informed consent.

The purpose of the study is to examine Canadian mothers' contemporary experiences accessing abortion.

You are eligible to participate in this study if you identify currently self-identify as a mother over the age of 18 AND have experienced an elective abortion in the last **2 years.**

If you volunteer for this research, you will be asked to participate in a 60-90 minutes interview with the researcher. You will be asked for your consent to be audiotaped during the interview. The video technology (Zoom or Skype) will only be used as a means for the interview and will not be recorded.

The interview will ask you to share your abortion experience as a mother. The interview will allow you to explore and tell your story in any way that you wish to tell it. In addition to the story that you share, the interview may also ask about your specific experiences accessing abortion; and ask you to share details of the facilitators and barriers to access, and details about being a mother and having an abortion.

No harm is intended as part of this study. However, it is possible that the research topic may provoke undesirable feelings of discomfort or grief. Recognizing this possibility, you will be encouraged to share your abortion/motherhood story in ways that feel uniquely comfortable to you. You may choose to limit what you share at any time during the study. Participation in the study is completely voluntary. You may choose to not answer a question, or withdraw for the study at any time without penalty. No-cost counselling resources will be made available to you.

There may not be any direct benefits to you by participating in this research. However, this information may present an opportunity for you to share details of your abortion experiences and/or the conditions of motherhood in Canada. Your participation in this research may contribute to future implications for

mothers' and women's continued full-spectrum reproductive rights in Canada. Your participation may have implications for nursing practice, e.g., it may inform the ways in which nurses and health care professionals understand and consider mothers' abortion experiences in their practice.

Your participation in the research is completely voluntary and you may choose to stop participating at any time. Your decision to stop participating, or to refuse to answer particular questions, will not affect your relationship with the researchers, York University, the abortion clinics or providers, or any other group associated with this project. In the event that you withdraw from the study, all associated data collected will be immediately destroyed wherever possible.

Your identity and the identity of organization that are discussed in the interview will only be known to the researcher(s), and will not be disclosed in the reporting of research findings. Any identifying information you provide will be safeguarded by encryption and password protection. Pseudonyms will be used to identify you and any quoted material you provide, in all reports and presentations made based on this research. Pseudonyms will also be used to identify the abortion clinic and any others involved in your care, or that you name in the process of describing your experiences.

The interview will take place in a mutually convenient, private, secure, and confidential setting agreed upon by you and the researcher. The interview will be audiotaped and transcribed. You have the right to review/edit the recordings or transcripts.

All electronic data will be safely stored on and USB and in a locked facility for 5 years, and only the graduate researcher and research supervisor will have access to this information. After 5 years, the files will be destroyed. After 5 years, paper data including consents will be shredded; the confidential transcripts will be erased and electronic files deleted.

Participation in this study is completely separate from your medical record. Your participation in this study will not be linked with your medical history, electronic medical record, or any medical file you may have.

Confidentiality will be provided to the fullest extent possible by law.

In appreciation for your time, you will receive $20 in the form of a virtual coffee gift card sent by text or e-mail, if you are willing to share your e-mail or phone number for this purpose.

You may incur costs to participate in time, travel, or childcare costs. Allocations have been made to reimburse you for your voluntary participation, as listed above.

If you have any questions about the research in general, or your role in the study, you should contact me Margaret Lebold, RN, BScN, MScN Student, by email, or Dr. Judith MacDonnell, RN, PhD, Graduate Student Supervisor, by e-mail. This research has been approved by the York University Faculty of Graduate Studies, Human Participants Review Sub Committee, York University's Ethics Review Board, and conforms to the stands of the Canadian Tri-Council Research Ethics Guidelines. If you have any questions about this process or about your rights as a participant in this study, you may contact the Senior Manager and Policy Advisor for the Office of Research Ethics.

Do you have any questions?

[Once all questions answered]

Do you consent to participate in the study entitled **Canadian Mothers' Contemporary Experiences Accessing Abortion as you have heard it described?**

Do you agree that you understood the nature of this project, that you have had an opportunity to ask questions, and wish to participate?

Do you understand that you are not waiving any of your legal rights by agreeing to participate?

Furthermore, do you consent to be audiotaped in the study interview and understand that the audio recording will be permanently deleted after it is transcribed?

Verbal Consent by:

Principal Investigator name: _____
Principal Investigator signature: _____
Date: _____
Time: _____
Place: _____

For, the following participant:

Participant name: _____
Date: _____
Time: _____
Place: _____

Record if consent withdrawn:
Participant name: _____
Date: _____
Time: _____
Place: _____

By: Principal Investigator name: _____
Date: _____
Time: _____
Place: _____
Signature of Principal Investigator: _____

Appendix E - Demographic Data

1. **What is your current age?**
   - **18-19**
   - **20-24**
   - **25-29**
   - **30-34**
   - **35-39**
   - **40-44**
   - **45-49**
   - **>50**
2. **What is your highest level of education?**
   - **Less than high school**
   - **High school diploma**
   - **Some college or university**
   - **Completed college diploma or university undergraduate degree (BSc)**
   - **Graduate degree (PhD, Master)**
3. **What type of elective abortion(s) have you had?**
   - **Medical (took pills)**
   - **Surgical (procedure)**
   - **Both**
4. **If you feel comfortable, please indicate if you identify as belonging to any of the following groups:**

   □ Visible minority **□ LGBTQ2S+**

   □ Living with a disability **□ English is not your first language**

5. **Please provide the first 3 digits of your current postal code: _____**

Appendix F - Interview Questions

Q1: Can you tell me about your experience(s) with abortion?

Q2: Can you tell me about what accessing abortion was like for you?

Q3: Can you share with me how you felt and what influenced you to have an abortion? What barriers, if any did you face? What supports, if any, did you find helpful or would have found helpful?

Q4: Can you tell me what it means to be a mother and to have an abortion?

Appendix G - Administrative Permission Request

My name is Margaret Lebold, I am a registered nurse and Masters of Science in Nursing student at York University. I am currently working on my thesis project entitled: **Canadian Mothers' Contemporary Experiences Accessing Abortion** under the supervision of Dr. Judith MacDonnell. The aim of my research is to explore, through a critical feminist and nursing lens, the contemporary experiences of diverse Canadian mothers accessing abortions in Ontario.

I am reaching out to you and your abortion clinic to seek permission to recruit a small sample of participants for in-depth interviews through your clinic. With your permission, I am hoping to display posters in your clinic providing details of the study, and my contact information for interested participants. In addition, I can also make myself available to attend your clinic on a mutually convenient day to explain the study and to separately answer any questions that you, your staff, or potential participants may have. The study interview between myself and voluntary participants would take place outside of your site. I have attached the York University approved ethics poster for your review.

Please let me know if you are willing to assist with the recruitment aspect this research project by completing the attached letter permission and resubmitting to me. Thank you.

Margaret Lebold, RN, BSc, BA, BScN

Masters of Science in Nursing Student, York University

Supervisor: Dr. Judith MacDonnell

Appendix H - Updated Appendices

Updates include modifications to Appendix A, C, D, F, & G.

Appendix A – Revised.

Looking for women to share their experiences of abortion

Are you:

- A woman, over the age of 18, living in Canada,
- And, you made the decision to have an abortion (either by procedure or by abortion pill) in the last 3 years?

If you answered yes to the above questions, you are invited to volunteer for this study of Canadian women's contemporary experiences accessing abortion.

You will be asked to participate in an interview and to tell your story of abortion. A part of the interview will ask about your thoughts about motherhood.

Your participation will include one interview, and the chance, if you wish, to review the story that you told the interviewer. The time expected for the interview is about 1 hour.

In appreciation for your time, you will receive $20 in the form of coffee gift card and be reimbursed $20 to cover childcare and/or transportation costs.

If you are interested in participating in this study or for more information please contact:

Margaret Lebold, Registered Nurse (RN), Master of Nursing Student, York University, Faculty of Graduate Studies, School of Nursing.

In choosing this study and focusing it on women's experiences of abortion, I convey my values as a feminist nurse committed to social justice, including supporting women's full rights to reproductive health, including abortion.

This research study has been reviewed and approved by the York University Research Ethics Board.

Appendix C – Revised.

Appendix C- Informed Consent Form - Women

Canadian Women's Contemporary Experiences Accessing Abortion

Researchers:
Margaret Lebold, RN, BScN (Student, Masters of Science in Nursing Program at York University)
Supervisor: Dr. Judith MacDonnell, Associate Professor, School of Nursing, York University

Introduction:
You are being invited to participate in a research study looking at Canadian women's recent experiences with abortion access. Before agreeing to participate in the study, it is important that you read and understand the information contained in the consent. The informed consent contains information that you need to know and understand in order to decide whether you wish to participate in the study. If you have any questions or would like clarification about the study, please contact the researchers. Only after reading through the informed consent in full, and understanding its contents, should you sign below.

The purpose of the study:
The purpose of the study is to examine Canadian women's contemporary experiences accessing abortion, with a focus on women's intersecting thoughts about motherhood.

Eligibility:
You are eligible to participate in this study if you identify currently self-identify as a woman over the age of 18 AND have experienced an elective abortion in the last **3 years.**

What you will be asked to do in the research:
Should you volunteer for this research, you will be asked to participate in a 60-90 minute interview with the researcher. You will be asked for your consent to be audiotaped during the interview.

The interview will ask you to share your abortion experience. Questions will ask about your abortion experience and other questions, such as motherhood, and supports and barriers to abortion access.

Potential risks and discomforts to you as a participant:
No harm is intended as part of this study. However, it is possible that the research topic may provoke undesirable feelings of discomfort or grief. Recognizing this possibility, you will be encouraged to share your abortion/motherhood story in ways that feel uniquely comfortable to you. You may choose to limit what you share at any time during the study. Participation in the study is completely voluntary. You may choose to not answer a question, or withdraw for the study at any time without penalty. A list of no-cost counselling resources will be made available to all participants.

Potential benefits:
There may not be any direct benefits to you by participating in this research. However, this information may present an opportunity for you to share details of your abortion experiences and/or the conditions of motherhood in Canada. Your participation in this research may contribute to future implications for mothers' and women's continued full-spectrum reproductive rights in Canada. Your participation may have implications for nursing practice. For instance, it may inform the ways in which nurses and health care professionals understand and consider women's and mothers' abortion experiences in their practice.

Voluntary participation:
Your participation in the research is completely voluntary and you may choose to stop participating at any time. Your decision to not continue participating will not influence your relationship or the nature of your relationship with the researchers or with staff at York University, either now, or in the future.

Withdrawal from the study:
You may stop participating in the study at any time, for any reason, if you so decide. Your decision to stop participating, or to refuse to answer particular questions, will not affect your relationship with the researchers, York University, the abortion clinics or providers, or any other group associated with this project. In the event that you withdraw from the study, all associated data collected will be immediately destroyed wherever possible.

Confidentiality:
Your identity and the identity of the abortion clinic will only be known to the researcher(s), and will not be disclosed in the reporting of research findings. Identifying information will be safeguarded by encryption and password protection (e.g., informed consent). Pseudonyms will be used to identify you and any quoted material you provide, in all reports, and presentations made based on this research.

The interview will take place in a mutually convenient, private, secure, and confidential setting agreed upon by you and the researcher. Accommodations will be made for participants who may prefer to interview via skype/zoom technology and cannot arrange to meet in person. The interview will be taped and transcribed. You have the right to review/edit the recordings or transcripts.

All data will be safely stored in a locked facility for 5 years, and only the graduate researcher and research supervisor will have access to this information. After 5 years, the files will be destroyed. Paper data including consents will be shredded; the confidential transcripts will be erased and electronic files deleted.

Participation in this study is completely separate from your medical record. Your participation in this study will not be linked with your medical history, electronic medical record, or any file you may have.

Confidentiality will be provided to the fullest extent possible by law.

Incentives for Participation:
In appreciation for your time, you will receive $20 in the form of coffee gift card and be reimbursed $20 to cover childcare and/or transportation costs. In the event that you withdraw from the study, you will still receive all incentives.

Costs to Participate:
You may incur costs to participate in time and travel. Allocations have been made to reimburse you for your voluntary participation, as listed above.

Questions about the research?
If you have any questions about the research in general, or your role in the study, you should contact Margaret Lebold, RN, BScN, MScN Student, by email, or Dr. Judith MacDonnell, RN, PhD, Graduate Student Supervisor, by e-mail. This research has been approved by the York University Faculty of Graduate Studies, Human Participants Review Sub Committee, York University's Ethics Review Board, and conforms to the stands of the Canadian Tri-Council Research Ethics Guidelines. If you have any questions about this process or about your rights as a participant in this study, you may contact the Senior Manager and Policy Advisor for the Office of Research Ethics.

Legal Rights and Signatures:

I, _____, consent to participate in the study entitled **Canadian Women's Contemporary Experiences Accessing Abortion** conducted by nursing graduate student, Margaret Lebold with supervision from Dr. Judith MacDonnell. I have understood the nature of this project and wish to participate. I am not waiving any of my legal rights by signing this form. My signature below indicates my consent.

Furthermore, I consent to be audiotaped in the study interview and understand that the audio recording will be transcribed and will be permanently deleted after transcription.

Participant name: _____
Participant signature: _____
Date: _____

Principal Investigator name: _____
Principal Investigator signature: _____
Date: _____

Appendix D – Revised.

Appendix D – Verbal Informed Consent Script - Women

The following verbal informed consent will be used in the event that a participant chooses to participate via Skype or Zoom versus in-person, and who cannot provide a written informed consent. In this case, the form will be read verbatim.

You are being invited to participate in a research study looking at Canadian women's recent experiences with abortion access. The study is called 'Canadian Women's Contemporary Experiences Accessing Abortion' and is being conducted by myself, Margaret Lebold (a registered nurse (RN) and Masters student in the school of nursing at York University). If you have any questions or concerns about the study, I can be contacted by e-mail or via the office of graduate studies at York University. I am being supervised by Dr. Judith MacDonnell, Associate Professor in the School of Nursing at York University. Dr. MacDonnell can be reached by e-mail.

Before agreeing to participate in the study, it is important that you understand the information that I will read to you now, which comprises the informed consent and replaces a written consent form. This verbal informed consent contains information that you need to know and understand in order to decide whether you wish to participate in the study. If you have any questions or would like clarification about the study, please contact myself, or Dr. Judith MacDonnell. Only after listening to the informed consent in full, and understanding its contents, should you agree to participate. If you agree to participate, I, the researcher, will record your name, the date and time you agreed to the consent, and keep this information on a password protected file, on an encrypted USB to fulfill the requirements of maintaining a record of obtained informed consent.

The purpose of the study is to examine Canadian women's contemporary experiences accessing abortion, with a focus on women's intersecting thoughts about motherhood.

You are eligible to participate in this study if you currently self-identify as a woman over the age of 18 AND have experienced an elective abortion in the last **3 years.**

If you volunteer for this research, you will be asked to share your abortion experience. Other questions will ask about your thoughts about motherhood, and supports and barriers to abortion access.

What you will be asked to do in the research:
Should you volunteer for this research, you will be asked to participate in a 60-90 minute interview with the researcher. You will be asked for your consent to be audiotaped during the interview.

No harm is intended as part of this study. However, it is possible that the research topic may provoke undesirable feelings of discomfort or grief. Recognizing this possibility, you will be encouraged to share your abortion/motherhood story in ways that feel uniquely comfortable to you. You may choose to limit what you share at any time during the study. Participation in the study is completely voluntary. You may choose to not answer a question, or withdraw for the study at any time without penalty. No-cost counselling resources will be made available to you.

There may not be any direct benefits to you by participating in this research. However, this information may present an opportunity for you to share details of your abortion experiences and/or the conditions of motherhood in Canada. Your participation in this research may contribute to future implications for mothers' and women's continued full-spectrum reproductive rights in Canada. Your participation may have implications for nursing practice, e.g., it may inform the ways in which nurses and health care

professionals understand and consider women and mothers' abortion experiences in their practice.

Your participation in the research is completely voluntary and you may choose to stop participating at any time. Your decision to stop participating, or to refuse to answer particular questions, will not affect your relationship with the researchers, York University, the abortion clinics or providers, or any other group associated with this project. In the event that you withdraw from the study, all associated data collected will be immediately destroyed wherever possible.

Your identity and the identity of organization that are discussed in the interview will only be known to the researcher(s), and will not be disclosed in the reporting of research findings. Any identifying information you provide will be safeguarded by encryption and password protection. Pseudonyms will be used to identify you and any quoted material you provide, in all reports and presentations made based on this research. Pseudonyms will also be used to identify the abortion clinic and any others involved in your care, or that you name in the process of describing your experiences.

The interview will take place in a mutually convenient, private, secure, and confidential setting agreed upon by you and the researcher. The interview will be audiotaped and transcribed. You have the right to review/edit the recordings or transcripts.

All electronic data will be safely stored on and USB and in a locked facility for 5 years, and only the graduate researcher and research supervisor will have access to this information. After 5 years, the files will be destroyed. After 5 years, paper data including consents will be shredded; the confidential transcripts will be erased and electronic files deleted.

Participation in this study is completely separate from your medical record. Your participation in this study will not be linked with your medical history, electronic medical record, or any medical file you may have.

Confidentiality will be provided to the fullest extent possible by law.

In appreciation for your time, you will receive $20 in the form of a virtual coffee gift card sent by text or e-mail, if you are willing to share your e-mail or phone number for this purpose. In the event that you withdraw from the study, you will still receive all incentives.

You may incur costs to participate in time, travel, or childcare costs. Allocations have been made to reimburse you for your voluntary participation, as listed above.

If you have any questions about the research in general, or your role in the study, you should contact me Margaret Lebold, RN, BScN, MScN Student, by email, or Dr. Judith MacDonnell, RN, PhD, Graduate Student Supervisor, by e-mail. This research has been approved by the York University Faculty of Graduate Studies, Human Participants Review Sub Committee, York University's Ethics Review Board, and conforms to the stands of the Canadian Tri-Council Research Ethics Guidelines. If you have any questions about this process or about your rights as a participant in this study, you may contact the Senior Manager and Policy Advisor for the Office of Research Ethics.

Do you have any questions?

[Once all questions answered]

Do you consent to participate in the study entitled **Canadian Women's Contemporary Experiences Accessing Abortion as you have heard it described?**

Do you agree that you understood the nature of this project, that you have had an opportunity to ask questions, and wish to participate?

Do you understand that you are not waiving any of your legal rights by agreeing to participate?

Furthermore, do you consent to be audiotaped in the study interview and understand that the audio recording will be permanently deleted after it is transcribed?

Verbal Consent by:

Principal Investigator name: _____
Principal Investigator signature: _____
Date: _____
Time: _____
Place: _____

For, the following participant:

Participant name: _____
Date: _____
Time: _____
Place: _____

Record if consent withdrawn:
Participant name: _____
Date: _____
Time: _____
Place: _____

By: Principal Investigator name: _____
Date: _____
Time: _____
Place: _____
Signature of Principal Investigator: _____

Appendix F – Revised.

Appendix F - Interview Questions - Women

Q1: Can you tell me about your experience(s) with abortion?

Q2: Can you tell me about what accessing abortion was like for you?

Q3: Can you share with me how you felt and what influenced you to have an abortion? What barriers, if any did you face? What supports, if any, did you find helpful or would have found helpful?

Q4: Can you tell me about your thoughts about motherhood and its challenges? Or, what it means, to you, to be a mother and to have an abortion?

Appendix G – Revised.

Appendix G – Administrative Permission Request

My name is Margaret Lebold, I am a registered nurse and Masters of Science in Nursing student at York University. I am currently working on my thesis project entitled: **Canadian Women's Contemporary Experiences Accessing Abortion** under the supervision of Dr. Judith MacDonnell. The aim of my research is to explore, through a critical feminist and nursing lens, the contemporary experiences of diverse Canadian women accessing abortions in Canada, with a focus on the experiences of mothers and/or women's thoughts about motherhood.

I am reaching out to your organization to seek permission to post a recruitment flyer at your location(s) in order to recruit a small number of participants for my study. With your permission, I am hoping to display posters at your facility/on your community board (or similar), providing details of the study, and my contact information for interested participants. For interested participants, the study interview between myself and voluntary participants would take place outside of your site. I have attached the York University approved ethics posters for your review.

Please let me know if you are willing to assist by posting and I will forward flyers by mail, or in person, if possible.

Thank you in advance,

Margaret Lebold, RN, BSc, BA, BScN

Masters of Science in Nursing Student, York University

Supervisor: Dr. Judith MacDonnell